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ABSTRACT

CityMatCH is a national organization of urban maternal and child health programs and leaders. In 1995, CityMatCH sponsored a conference at which urban maternal and child health leaders from city and county health departments across the country came together for professional development and networking. This report of highlights from the conference presents summaries of the following papers as selected remarks from the conference: (1) "Opening Remarks" (Peter Morris); (2) "The Essential Ingredients of a Successful Community Partnership" (David Satcher); (3) "Re-Inventing Public Health" (Hugh F. Stallworth); (4) "Protect Children, not Guns: What Are the Next Steps?" (Katherine Kaufer Christoffel); (5) "Total Quality Management Workshop Summary" (Irene Bindrich); and (6) "Closing Remarks" (Carolyn Slack). These summaries are followed by an index of cities profiled in 1995 (in chart form). The bulk of the report consists of 70 program descriptions, which include information about objectives, accomplishments, funding, community partners, and program evaluation. A list of program participants is attached. (SLD)

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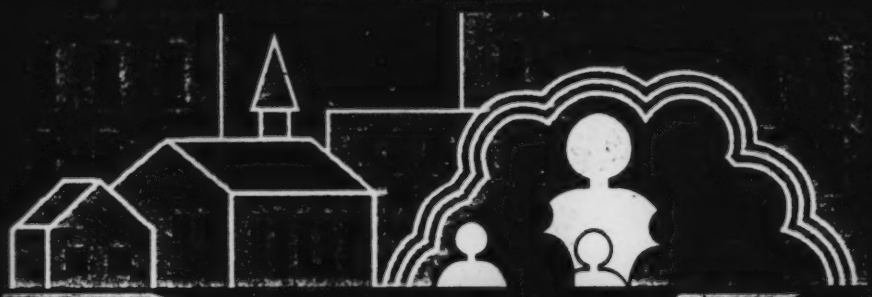

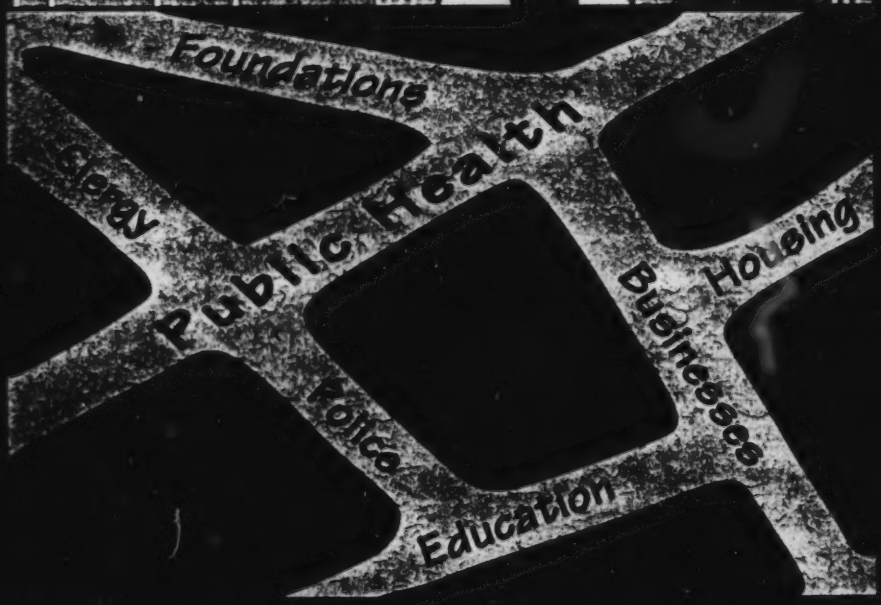

Community Partnerships

September 14-16, 1995 Chica

Conference Highlights

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"The Road to Community Partnerships"

Highlights of the
1995 Urban Maternal & Child Health Leadership Conference

September 14 - 16, 1995

The Palmer House Hilton
17 East Monroe Street
Chicago, Illinois

Editors

Daniel G. Koenig, B.S.
Magda G. Peck, Sc.D.

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CityMatCH is a national organization of urban maternal and child health programs and leaders. CityMatCH was initiated in 1988 to address the need for increased communication and collaboration among urban and maternal and child health programs for the purpose of improving the planning, delivery, and evaluation of maternal and child health services at the local level. CityMatCH, through its network of urban health department maternal and child health leaders, provides a forum for the exchange of ideas and strategies for addressing the health concerns of urban families and children. CityMatCH also has developed a centralized information base about the current status of maternal and child health programs and leaders in major urban health departments in the United States. For more information about CityMatCH, contact Dr. Magda Peck, CityMatCH Executive Director, Department of Pediatrics, University of Nebraska Medical Center, Post Office Box 982170, 600 South 42nd Street, Omaha, NE 68198-2170, Phone: (402) 559-8323.

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Acknowledgments

Improving communication and collaboration among urban MCH programs is at the core of the CityMatCH mission. For the sixth year, urban maternal and child health leaders from city and county health departments from across the country came together for professional development and networking. While they commented widely on the thrill and productivity of being together, the hard work that went into putting the conference on did not go unnoticed. A magnificent team of Conference organizers, coordinators, and administrators did a stellar job once again.

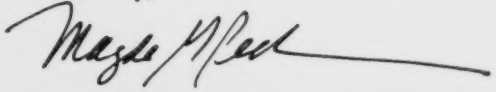
This was a meeting of quiet firsts. We took the Urban MCH Leadership Conference on the road for the first time. After five good years in Washington, D.C., we headed to Chicago, Illinois where Conference Co-Chair Shirley Fleming and her glorious crew in the Chicago Health Department were wonderful hosts. And this was the first year the conference was staffed by CityMatCH alone.

CityMatCH is fortunate to sustain a small, excellent staff in the Section on Child Health Policy, Department of Pediatrics at the University of Nebraska Medical Center in Omaha, Nebraska. CityMatCH Administrative Technician, Joan Rostermundt, handled logistics with grace and efficiency while Conference Coordinator Harry Bullerdiek effectively organized and managed the conference details. Elice Hubbert, CityMatCH Coordinator of Special Projects, lent her expertise to processing Profiles and organizing the Data Workshops and SpotLight Awards. Additional staff assistance, during and after the Conference, came from Diana Fisaga, Chris Kerby, Patrick Simpson, Tim Petersen and Dan Koenig.

Conference Co-Chair's Peter Morris, Health Director, Wake County Health Department, Raleigh, North Carolina, and Shirley Fleming, Deputy Health Commissioner, Chicago Department of Health did a marvelous job of leading the CityMatCH family. A hard working and creative Conference Planning Committee shaped the program, secured effective speakers and guided us through the planning process. As always, we are indebted to our many funders and co-sponsors whose support is undeniably essential.

The Conference enhanced the CityMatCH mission of fostering the active participation among MCH directors and presented the opportunity to increase their knowledge, skills, abilities and renew their commitment to urban MCH. I acknowledge, with great appreciation and gratitude, the hard work of every individual who makes the special connections within the CityMatCH family happen.

Sincerely,



Magda G. Peck, ScD
CityMatCH Executive Director & CEO

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Opening Remarks

Peter Morris, M.D., MPH, Conference Co-Chair
MCH/Clinical Services Division Director
Wake County Department of Health

Good morning. Let me add my voice to the chorus of welcomes to this year's CityMatCH conference: *The Road to Community Partnerships*.

In the tradition of Magda Peck, CityMatCH's Executive Director, I want to open with a story. Attendees from years past know how Magda weaves stories of her own personal and family growth with the evolution of CityMatCH, often describing an episode with one or both of her sons.

Morris

I am not as clever as Magda; but still, I have a story.

Premedical studies were never for me the horrors sometimes depicted. On the first day of general chemistry, no one asked me to look left; look right; and wonder which student would not be seated here in one short year.

Nor, were medical school interviews wrought with horror. No one tested my reaction to stress by calmly asking me to open a window, a window that could not be opened as it was nailed shut.

What have these stories to do with CityMatCH?

Each year CityMatCH notes our transitions. Generally, one in three MCH directors of member health departments change each year: many promoted within their organizations, some retired, and some choosing new career paths. This year, nearly two thirds of members are new MCH directors.

Look left; look right. Two of you may not be here this time next year.

Should we be troubled by these transitions? I think not.

There is sadness in these passings, but joy as well. Our alumni have moved on to university health services, returned to front line provider roles, taken positions in managed care organizations--as many opportunities as there have been replacements.

Rejoice at least at this: we are employable.

And celebrate.

Celebrate, as we have alumni in places where we need friends; people in managed care organizations who don't wrinkle their brows when we say we are in public health, maternal and child health.

We have potential partners.

This year's conference is a celebration of change: from Washington to Chicago, from the Beltline to the Loop, from an insulated reality to the Windy City where we may well be buffeted by forces, some not yet identified.

This year is a celebration of change, as CityMatCH now staffs this conference on its own. Please, each time you see staff, or someone wearing a blue ribbon, thank them for the often thankless work that goes into taking CityMatCH on the road.

This year is a celebration of change, for maternal and child health will never be the same. Title V will survive, but MCH will never be the same. Block grants may emerge, but MCH can never be the same. Managed care will mature, and so shall we.

But what shall we be? In a word, indispensable.

Through knowledge, expertise, and data, and our ability to use these tools to serve a public deserving of service, we will be indispensable.

The CityMatCH conference has always been about coming together, a gathering of peers, a fellowship, and now...

"By joining and pointing the way with new and innovative partnerships, we may replace never truly secure fiscal resources with far more valuable personal resources--our new partners."

And now, there are strangers in our midst. Embrace them. Welcome them. And welcome the possibilities that accompany new friendships. By joining and pointing the way with new and innovative partnerships, we may replace never truly secure fiscal resources with far more valuable personal resources--our new partners.

We have a window of opportunity, and it is not nailed shut. It needs only be flung open and, standing in the breeze, we need take a deep breath, lean out into the sunshine and possibilities, and greet this new day with joy and zest.

Selected Remarks

The Essential Ingredients of a Successful Community Partnership

David Satcher, M.D. Ph.D.
Director, Centers for Disease Control and Prevention

This text is the basis of Dr. David Satcher's oral remarks. It should be used with the understanding that some material may have been added or omitted during the presentation.

Given the complexity and severity of health problems in our cities, (such as deterioration of infrastructure, increased poverty, loss of the middle class, and other concerns), we haven't asked our cities, as unique communities with unique problems and unique strengths, to become more actively involved in developing and implementing the solutions to health problems at local levels. We should be working together to identify common solutions and approaches. These solutions should incorporate the unique strengths of urban populations and foster a reestablishment of a sense of community.

This is why groups like CityMatCH provide a joint voice for specific problems and issues enabling cities to take charge of their own problems as a group.

CDC has many examples of collaborative partnership work at local community levels. These include the work on the Black-White Gap Infant Mortality in Atlanta, Los Angeles, and New York City; the HIV Community/Planning Projects; The Prevention Centers; and a recently initiated Urban Epidemiology Center.

Various epidemiologic study designs and methodologic techniques to adjust for known risk factors have not adequately explained the increased risks of adverse pregnancy outcomes in African Americans.

Because pregnancy is a biological and sociocultural process, an interdisciplinary approach which includes ethnography is essential to provide a description and analysis of the historical, sociocultural, psychological, behavioral, environmental, and biological factors and contexts which may influence maternal health and pregnancy outcomes.

"We should be working together to identify common solutions and approaches. These solutions should incorporate the unique strengths of urban populations and foster a reestablishment of a sense of community."

In response, in 1992 CDC issued two three-year contracts to: 1) conduct ethnographic research on maternal health during pregnancy and pregnancy outcomes among African Americans in the United States; 2) investigate community concerns about observational studies; and 3) evaluate the process of active community participation in the current research. The participating communities in Los Angeles and New York City have an active role in the definition of research questions, research conduct, data analysis, and development of future work. This approach addresses concerns about participation and encourages disclosure of life stories.

CDC's work in these contracts focuses on understanding the diversity of risk and protective factors and contexts among African-Americans and provides the foundation for subsequent qualitative and quantitative studies, for the development of culturally - and socially-appropriate prevention and intervention strategies, and for understanding the dynamics of community partnerships in public health. The approach is new for CDC. In this work, we asked communities to help select "research" questions and how to study them. In previous work, communities were often asked to help with interventions but rarely to design research.

Satcher

CDC's work is also innovative in assessing processes of community partnerships.

Through our work with community partners concerning HIV and chronic disease prevention and maternal child health activities, we have learned the following lessons:

1) It is imperative to involve the "community" from the start of a project. Being a partner means involvement in the conceptualizing, planning, and conduct of a project as well as in the analysis, interpretation, writing, and solutions phases.

We expect the community to work with us to decide what should be studied and how. It is a joint learning of how to work together.

The "community has many "layers" through which one has to work. CDC held workshops and symposiums, with community voices, to improve our concept of needed research and its conduct. Our subsequent contracts were then designed with a planning year so the local community could be an active partner in the entire process.

2) One has to respect the different views and perspectives of the community. Listening is critical. Community expertise is as valuable as scientific expertise.

It is important to acknowledge that people and

continued next page

David Satcher continued

groups have different skills--no one can do it all. We need to integrate these skills into a process and a team. Most community partnerships will be multidisciplinary by nature.

3) It is imperative to solicit, acknowledge, and address community concerns about the proposed research, prevention, or intervention activity. This collaboration must consider that scientific terms, such as "researchers," "data," and "anonymous," may have different meanings within the community, such as "takers," "stolen goods," and "secret purpose" (respectively).

"Being a partner means involvement in the conceptualizing, planning, and conduct of a project as well as in the analysis, interpretation, writing, and solutions phases."

4) The partners working with the local community should be active PARTNERS and help the community achieve what it wants. The community expects involvement and reciprocation (beyond money) by its partners in the community. The community wants access to the data collected in the community. Community-based research should also be applied within the researched community.

5) Often, as part of the collaborative process, the community needs education about what "public health" and "prevention" are. The community also needs to know how data, information, and science can help them obtain and target health resources.

6) Partnerships don't just happen. Community partnerships are time - and labor-intensive. It takes time and hard work to establish trust and effective, successful partnerships. One needs to build the infrastructure for partnerships, such as community organizations, coalitions, and working groups. These will have their own dynamics and problems which have to be considered.

7) The partnership process should facilitate the community working together to define and solve its own problems. It should foster multilevel empowerment and community ownership of problems and solutions. It should also be recognized that a community's priorities for improving health status may not match the researchers.

8) Continual networking is important. One must identify community gatekeepers and significant others who know about or should be part of the program process. This will include people not directly involved in health care or allied fields.

9) In collaborative work, the reality is that personalities matter, individuals matter, credibility matters, and integrity matters. Some people are not the right personality types for community collaborative work. Partners should be committed, honest, and readily acknowledge any limitations.

10) Each community will have its own unique features. To form effective community partnerships, one has to understand the community's history, demographics, and resources. There should be a working definition of what constitutes the "community." CDC's future work will include understanding and documenting the operation of the "community" process in collaborative partnerships.

11) One has to acknowledge and work with the fact that the community has multiple, integrated problems which are not compartmentalized the way public health often is. Health status in a community is affected by nonhealth factors.

12) Community collaborative partnerships need to discover and work within the diversity of the community. This includes promotion of positive factors and things people are doing right. Health partnerships should incorporate consideration of influences at levels beyond the individual. There should also be no victim blaming nor focus on a "deficit model."

13) In the partnership, one needs translation of information from a project directly to community, and not just to science. There should also be "vertical" translation (within the community or within science fields) as well as "horizontal" translation (from community to science or science to community).

14) The messenger delivering public health messages is important. The community may view a public health message differently when it comes from someone with authority in the community versus an outsider. The partnership should decide who the best messengers are and what format each message should have.

15) How data are interpreted is important in the partnership. The community wants the data to be used to solve problems and not to be used to perpetuate stereotypes, racism, and social neglect.

16) Administrative or bureaucratic problems can often sink a well-intentioned collaboration. Therefore for the partnership to succeed, these problems must be resolved.

17) There should be an ongoing evaluation of the collaborative process to assess whether we are doing the right things and doing things right. Everyone in the project should be kept informed about the process.

Selected Remarks

Re-Inventing Public Health

Hugh F. Stallworth, M.D.
Orange County Health Care Agency

I'm from Detroit, Motor City, Motown. We called it that, even before Barry Gordy, because we made more automobiles than any other city in the country. And I can remember, as a youngster, the excitement every year when the new car models were due to be unveiled. The dealerships had paper over the windows so you couldn't peek in. And the models you could see were covered so that all you could make out was the general shape. There were balloons, soft drinks, and spotlights. The whole process was exciting.

As I stand here today, I feel that same excitement. When I go to my office each morning, I feel that same excitement because we are in the process of unveiling a new public health, a new model. I can see a glimpse of the new body, the new lines, and imagine the power of the new engine. And, I hope that some of the concepts and experiences we share with you during this conference will help you to envision this new model.

We have read and heard the words of leaders like Dr. Satcher. We have heard the voices of those in our communities. And we've even heard the voices of our elected officials. And now we on the local level, in the trenches, are beginning to not only talk the talk, but walk the walk.

One of the problems we have in reinventing public health is that people don't know who we are or what we do. More importantly, we don't even know who we are and what we do. Many of us are so intently focused on our categorical areas and programs that we are unable to see the bigger picture of what public health is, and what it could become.

We in public health have gotten into the business of delivering health care services by default. Mainly because there has been no one else willing to step up to the window. We provide prenatal care, pediatric care, and in many instances, general medical care; and we render good care. But unless we really know and understand what public health is all about, we will not be receptive as managed care becomes more involved in our communities. We will not be receptive to relinquishing much of our roles as direct service providers and accepting more of our roles as public health professionals.

Well, what is public health and what do we do? Or more importantly, what do we need to be doing?

Public health is really a macrocosm of what your physician does in his office when he sees a patient. The physician's goal is to attain and maintain health, however he and the patient define it.

Our goal in public health is exactly the same; to attain and maintain the health of our patient. Only our patient is the community. Whether we're talking about the ongoing assessment, the health education, or the occasional need for treatment, our patient is the community. And there is no one else out there who is as prepared as we are to do that. Once we know who we are and what we do, how do we get the job done in this rapidly changing environment of decreasing funding and calls for downsizing government?

Stallworth

If there is one good thing that has come out of the bankruptcy in Orange County, it is that it has forced us to think about things differently. It created a fertile ground for change. Now, I'm not advocating bankruptcy as a viable stimulus for change, but it certainly got us off the dime. We began to talk to people and groups in the community:

1) We talked to the ones with the money, the funding sources. They were interested in hearing about how the bankruptcy affected public health. What we didn't realize was that these groups have been there all along, with a pocket full of money, looking for a place to spend it. We told them about our public health cuts ($3 million). We told them about some of the programs that were reduced or eliminated.

"But unless we really know and understand what public health is all about, we will not be receptive as managed care becomes more involved in our communities. We will not be receptive to relinquishing much of our roles as direct service providers and accepting more of our roles as public health professionals."

Then we proceeded to tell them something they didn't expect to hear. We told them that we weren't interested in filling in the potholes left from our fiscal war. What we were interested in was building new roads. We didn't present them with a laundry list of old programs we wanted them to finance, or buy back. We presented them with new ideas, new projects, new proposals, especially ones where we were collaborating with community groups.

continued next page

Hugh F. Stallworth continued

2) We talked with community-based organizations (CBOs). We began with those that were complaining the most and the loudest about what public health was not doing. I, and my staff, began going out and meeting with various groups. We met with Latino groups, Vietnamese groups, hospital groups, the clergy, and nonprofit groups. And, I've got to tell you that it is often difficult to sit there and listen to someone tell you what you're not doing, especially when you thought you were doing such a great job. But after we listened, we asked them to sit down, and we asked for their help:

"One of the problems we have in reinventing public health is that people don't know who we are or what we do."

A) Give us your thoughts on how public health should be involved in your community.

B) What are some of the problems and issues in your community?

C) How can we work with you?

D) Can we go after grant funding together?

We got some great ideas. Some of which I'll share with you in a few minutes. But one of the most important things we learned was that we all wanted the same thing: a healthy community. This was the genesis of our partnership building, or as we'd rather call it: strategic alliance building.

In building strategic alliances, we found we needed three components:

1) Expertise,

2) Funding source or sources, and

3) Access to target population.

It sounds so simple. But you'd be surprised how often partnerships attempt to address a public health issue while missing a critical component. Examples of some of our strategic alliances:

1) Latino Community: In our discussions with a Latino CBO, we found out about a very exciting idea that they had and wanted to implement; and it was consistent and compatible with a program we had been talking about. It involved taking people from the community, giving them basic medical and health training, and training them to assess health and teach prevention to their neighbors (not unlike the barefoot doctor concept).

A full-time public health nurse or community health nurse would coordinate their activities and act as the next level of expertise or bridge to public health. We presented a preliminary proposal to a funding source in the form of a three-year pilot project. They liked it and are talking to two other funding sources to come up with the money. It looks like it might come together.

Just think about some of the ramifications and the potential of this concept. We're talking about maximum access to the community. A foot in the door for issues like immunizations, infectious diseases, drug abuse, and violence. One neighbor listening and talking to another neighbor.

2) Vietnamese Community: In talking with a Vietnamese group, we found out they were going after an Office of Minority Health grant for a new community clinic. We agreed that the proposal would probably be stronger if they wrote in public health services being offered at the clinic. As a result of those discussions, we're going to be stationing one of our decentralized tuberculosis (TB) teams and an immunization team at the clinic site. Incidentally, this clinic site is located in a city with the highest TB rate of any city in the county. A win, win, win situation.

3) United Way: We formed a partnership with our local United Way. The issue that brought us together: childhood immunizations. In this alliance, United Way assumed the administrative function of our immunization outreach and tracking system development program (All Kids Count) and public health provided the expertise. It also was a win, win situation.

-- A win for United Way because they became associated with a positive public health program; childhood immunizations, and it didn't cost them anything.

-- A win for public health because we can market immunizations using, not a government entity, but the good name of United Way. We can ask for money and have it come to United Way and not a government agency.

-- A win for kids for obvious reasons.

Together we have submitted one grant application and will have a second one submitted this week. We think it works, and we're looking at expanding it.

4) CALOptima (Medicaid Managed Care): I just want to say a brief word about managed care because most of you, if you haven't already, will have to deal with it. I'm talking about medicaid managed care. Although we didn't form a formal partnership with our managed care program in Orange County, we formed an informal alliance. Public health was an integral part of laying the procedural and programmatic foundation for our managed care project. We made sure there was an

continued next page

Selected Remarks

Hugh F. Stallworth continued

understanding that the basis for any health care plan should not be just healthy individuals, but ultimately, a healthy community. We made sure there was strong emphasis on periodic childhood screening. We made sure the physicians made maximum efforts to not just enroll people, but to make sure they came in for an initial health screening. We developed a Memorandum of Understanding with the managed care plan that clearly outlined the interface with public health.

You're going to have to be assertive in this process because medicaid managed care programs often talk the talk of the importance of public health, but they fall short when it comes to walking the walk.

Let me share with you one other important thing we learned. That is, it is very appropriate for public health to take the lead in bringing issues forward to the attention of the community, in bringing different groups together, in facilitating discussions and in planning. But, public health doesn't have to fight over the drum major's baton. We don't have to be the boss or the know-it-all. What we have is expertise, a very vital part of the triad. And, if CBOs know that we are willing to share that expertise without being a dictator, we get more accomplished. **Remember this: people don't care what you know until they know that you care.**

In summary, we believe that we are a part of the community. We believe that we have a part to play. But then, so do other parts of the community. We are all in this together. If we fail to solve the problems and issues that face us as a community, as a society, all of us will suffer one way or another.

"You're going to have to be assertive in this process because medicaid managed care programs often talk the talk of the importance of public health, but they fall short when it comes to walking the walk."

Now, let me read to you a passage I find very appropriate. *Every morning in Africa, a gazelle awakens. It knows it must run faster than the lion or it will be killed. Every morning in Africa, a lion awakens. It knows it must run faster than the gazelle or it will starve. It does not matter whether you are a lion or a gazelle: when the sun comes up, you'd better be running. -- Author Unknown*

Protect Children, Not Guns:
What Are the Next Steps?
Katherine Kaufer Christoffel, M.D., M.P.H.
Director, Violent Injury Prevention Center

Firearm injury is affecting U.S. children and adolescent as never before. Mothers, along with urban maternal and child health providers, are well aware of the huge scale and cost--in death, suffering and dollars. Because most firearm injuries and deaths are due to handguns, it is accurate to say that we are in the midst of an epidemic in which the handgun is the agent. Identifying handgun death and injury as a public health problem is in itself a first step to controlling the epidemic, one that is increasingly accepted in medicine and allied disciplines. This public health approach to the problem contrasts and complements the more traditional criminal justice approach to gun misadventures.

The means to defeat the handgun epidemic can be identified by the application of standard public health approaches. In any epidemic, the step after recognition must be the recording of the characteristics of the victims, the circumstances of the spread of the agent, and the consequences of suffering the epidemic condition. Targeted prevention approaches can then be developed, applied, and evaluated.

For the handgun epidemic, this means that the development of local, state, and national tracking systems must become a priority in every health department in every jurisdiction. The systems should ideally record the number and demographic characteristics of fatally and nonfatally injured persons, kinds of guns involved, gun owners, where they are stored and how they get to the injury scene. What leads to the use of the gun, the physical and mental health consequences of the injury to the victims and survivors, and the costs of these should also be recorded.

A good start on this would involve tracking of firearm injuries to children and adolescents. Though the rates are very high for this portion of the population, the total number in any given jurisdiction should be manageable. The motivation to protect potential victims in these age groups is usually very high, because of the stakes: years of potential life lost, mental health impairment, and long-term costs incurred. Maternal and child health providers can play a critical role in educating policy makers and voters about the importance of tracking this epidemic, and can be instrumental in implementing it.

The other critical role for MCH workers today is education of the mothers about the need to protect their children from handguns and how to do it. Two counseling aids will be discussed.

Total Quality Management Workshop Summary:
Irene Bindrich R.N., M.S.N., C.N.S.
Jefferson County Department of Health & Environment

In the world of public health, a consistent challenge has been presented, "Do more with less." As budgets are cut and services are offered in collaborative ventures, public health leaders are forced to look for new management tools to meet these challenges. "Total Quality Management in Public Health" was a new workshop offered at the 1995 Urban Maternal and Child Health Leadership Conference, which offered a new approach to meet this changing environment.

Len Foster and Irene Bindrich shed light on applying Total Quality Management (TQM) in the real world of government. Irene presented the principles of TQM and illustrated how TQM can be a success for improving customer satisfaction, increasing productivity and reducing waste in MCH programs. Len demonstrated the value of teamwork in a group exercise "Take Me Out to the Ball Game," which was fun and encouraged creativity from participants. Based on the evaluations, this workshop was very successful and timely for the participants.

Selected Remarks

Closing Remarks

Carolyn Slack, M.S., R.N., Past CityMatCH Chair
Columbus Health Department

We are in the last hour of our last day together. I am always simultaneously weary and exhilarated at this time in our conference. I am weary because this is a gathering at which I cannot mentally check out. I don't want to miss anything! I am exhilarated because I always bring home more information and more ideas I want to try.

We have a shared struggle which has been articulated throughout this meeting. We are struggling with what are our roles in service delivery. We are also struggling with performing our core public health functions.

Our conference has focused on community partnerships, actually *The Road to Community Partnerships*. I believe our struggle with the service delivery issue is more about the road part of our conference. Whether we participate fully in service delivery, or reduce our activities in this area, community partnerships will be essential to whatever road we take.

"Whether we participate fully in service delivery, or reduce our activities in this area, community partnerships will be essential to whatever road we take."

Hugh Stallworth spoke about how terribly focused we are on our categorical programs. As we scan our environment now, these programs seem comforting. They have provided us with very detailed maps of where we were to go and what we were to do. However, right now, there are no detailed maps and the road is under major construction.

Several months ago my daughter and I watched a wonderful film called, *Immortal Beloved*. It was about the life of Ludwig van Beethoven. While the major plot was around the women in his life, the secondary plot followed his professional career and the effect his deafness had on his life.

Beethoven did it all. He composed, performed, conducted and taught. As his deafness increased, some of his abilities (roles) became compromised. He responded with frustration and anger. There is a terribly painful scene in which his deafness becomes public. An orchestra is playing one of his symphonies. He is both performing and conducting. Soon the orchestra begins to lose it. He jumps up from his piano to focus on conducting and then sits down, yells for them to stop and start over with him. The orchestral members stop playing and cannot look at him. The symphony hall is soon as silent as the world is for Beethoven.

Beethoven disappears for many years. He re-emerges into the public eye for the premiere of his ninth symphony which contains the *Ode to Joy*. He starts out sitting in the audience watching the conductor and orchestra. He wanders up onto the stage. The film's director lets us be both the symphony audience (who hears the music) and Beethoven (who does not). However, although he cannot physically hear his music, his eyes convey that he does, indeed, hear the symphony.

Slack

Beethoven composed the *Ode to Joy* when he was totally deaf. He could not perform the music nor could he conduct the orchestra. His roles had changed. However, he could compose and the compositions of Beethoven continue to touch us today.

Our roles are changing. We talk about roles in the context of either steering or rowing. There are days when I look at my calendar and have to think - at the 10:00 a.m. meeting I am a rower and at the 1:30 p.m., I am a steerer. Actually, there are some days in which I think I am going to the meeting to build the boat.

There is a song that talks about being "..on the road again." Well the road is under construction, but that's okay because the result will be better roads. The map is not detailed, but that is okay because I like discovering and creating and going in new directions. I am not alone on this road. I am surrounded, through CityMatCH with trusted colleagues and friends who are sharing with me their experiences with detours, bumps and new highways. I thank each of you and bid you a safe and exciting journey.

Index of 1995 Profiled Cities

CityMatCH members attending the 1995 Urban MCH Leadership Conference were required to submit a profile discussing a successful MCH effort.

The profiles describe objectives, partnerships, accomplishments, funding sources, barriers and measures of success.

The profiles did not have to be a program or involve direct service provision, but should strengthen the capacity to serve children and families.

Each year, a CityMatCH committee reviews submitted profiles and presents a "SpotLight" award to those cities who have created outstanding, innovative and successful MCH initiatives. The 1995 recipients are **Miami, Florida, Omaha, Nebraska** and **Rochester, New York.**

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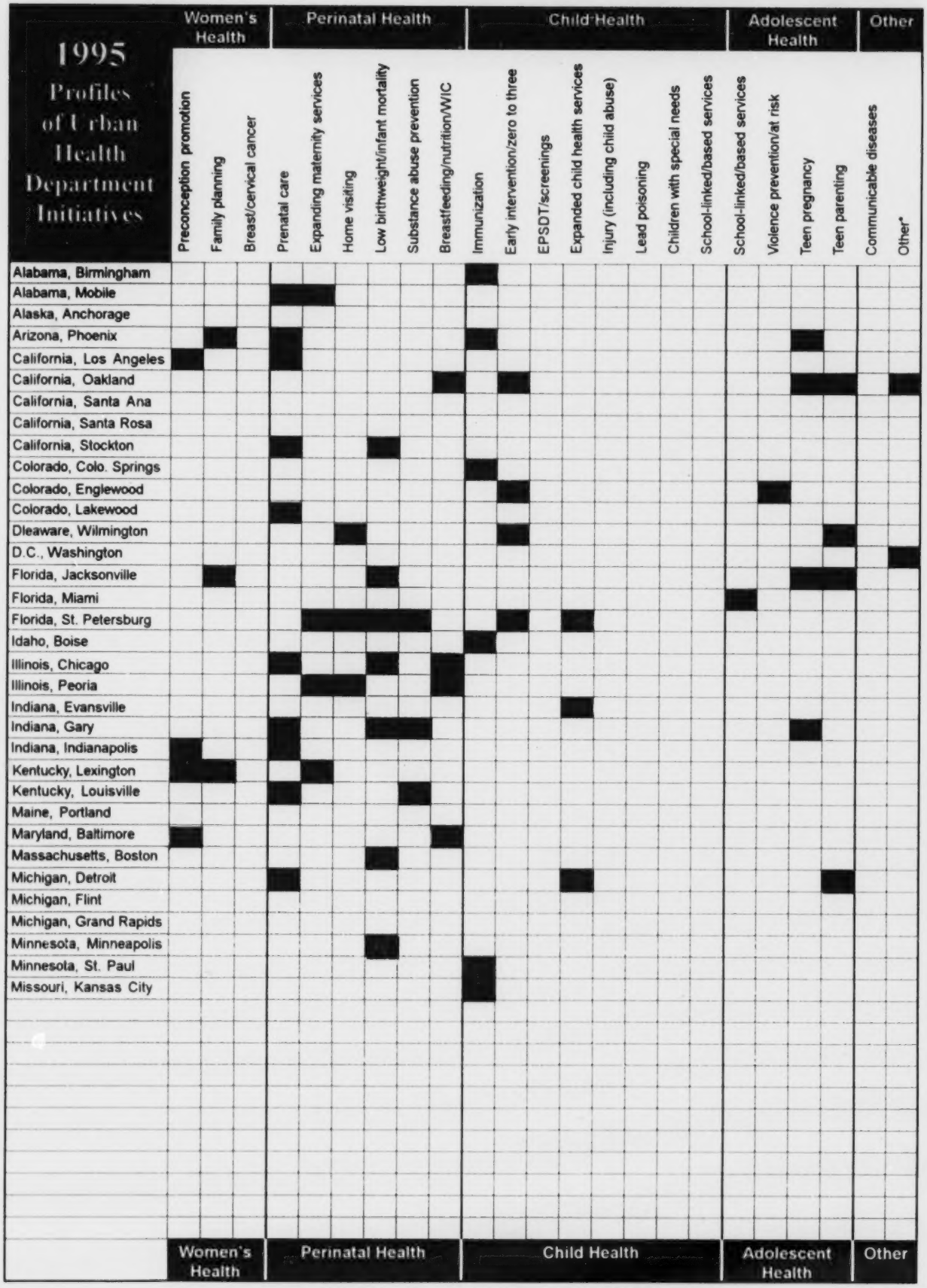
1995 Profiles of Urban Health Department Initiatives



1995 Profiles of Urban Health Department Initiatives

	Improving Access to Care for Urban Children and Families													Strengthening Urban Public Health Systems for MCH									
	Overcoming cultural barriers	Reducing transportation barrier	Expanding private sector links	Clergy & health connections	Housing & health connections	Schools & health connections	One-stop shopping locations	Mobile clinics for outreach	Other outreach activities	Increasing social support	Case coordination	Increasing access to Medicaid		Staff training	Strategic planning	Reshaping urban MCH	Securing MCH assistance	Managed care initiatives	Building coalitions/partnerships	Building MCH data capacity	Immunization tracking/recall	Infant/child death review	Other*
Alabama, Birmingham			■																■				
Alabama, Mobile		■																					
Alaska, Anchorage							■		■														
Arizona, Phoenix		■	■																				
California, Los Angeles																							
California, Oakland									■														
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California, Santa Rosa															■								
California, Stockton	■								■			■							■				
Colorado, Colo. Springs																							
Colorado, Englewood																							
Colorado, Lakewood																							
Dleaware, Wilmington			■								■								■				
D.C., Washington										■	■								■				
Florida, Jacksonville			■																■				
Florida, Miami			■			■																	
Florida, St. Petersburg																					■		
Idaho, Boise																							
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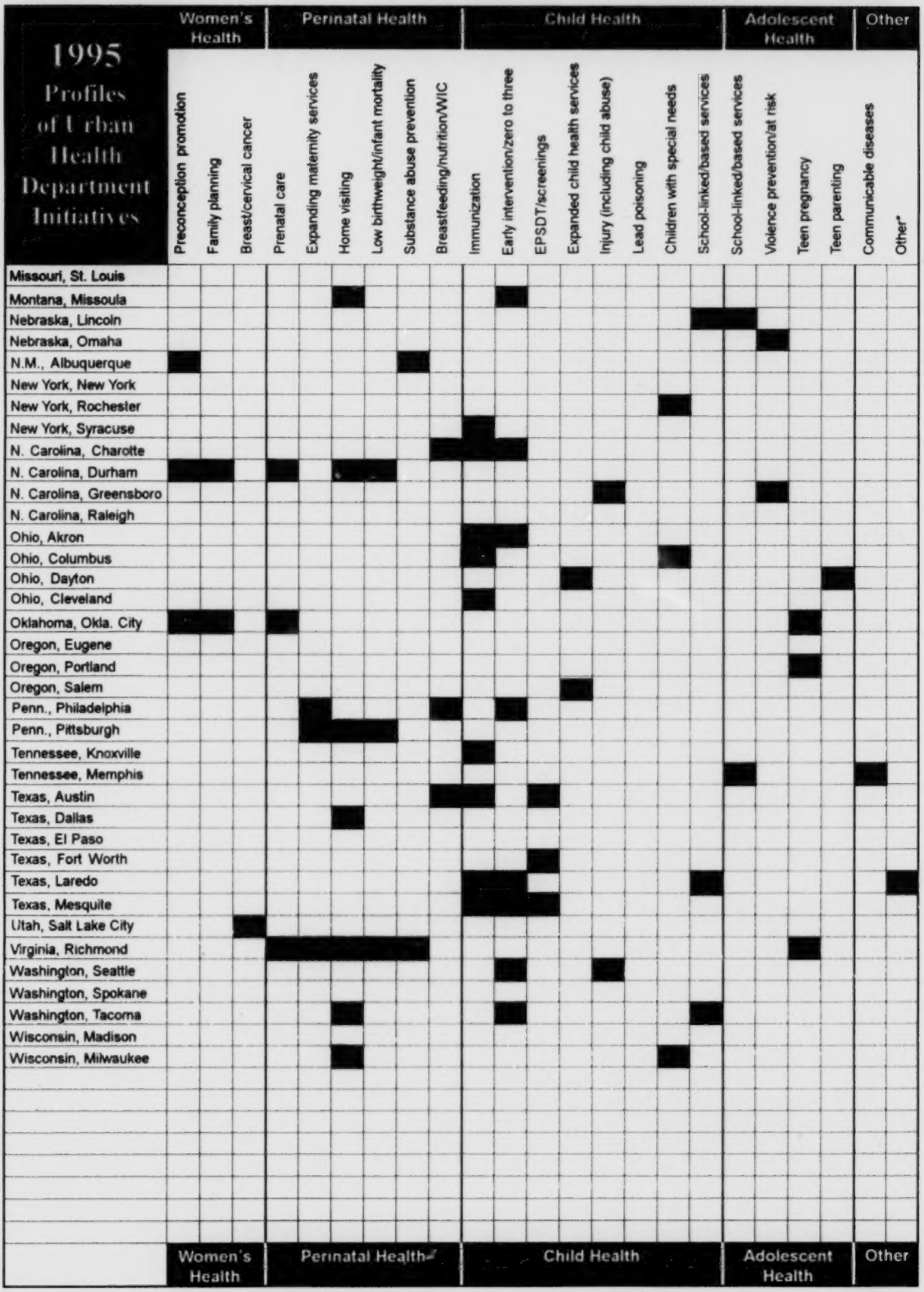
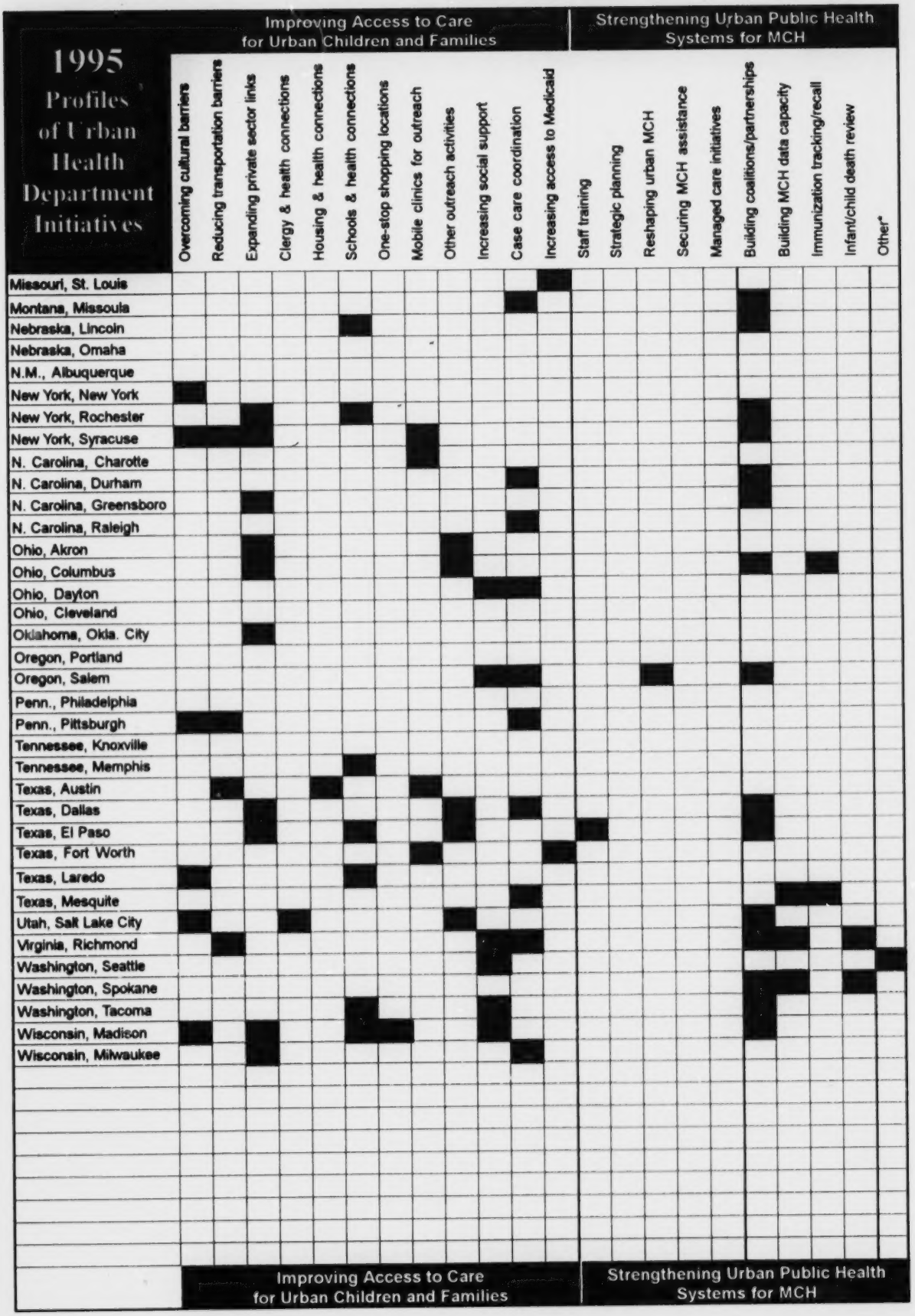
Maine, Portland	■										■												
Maryland, Baltimore																							
Massachusetts, Boston											■				■			■		■		■	
Michigan, Detroit											■								■				
Michigan, Flint	■			■		■			■	■		■											
Michigan, Grand Rapids															■				■				
Minnesota, Minneapolis																						■	
Minnesota, St. Paul			■						■												■		
Missouri, Kansas City																							
	Improving Access to Care for Urban Children and Families													Strengthening Urban Public Health Systems for MCH									

1995 Profiles of Urban Health Department Initiatives



1995 Profiles of Urban Health Department Initiatives



Birmingham, Alabama

Tot Shots Program

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Initiative Categories

Child Health	Access to Care
• Immunization	• Expanding private sector linkages
Strengthening Public Health	
• Building coalitions & partnerships	

Initiative Description

"When the clinics started, Jefferson County reported 58 percent of children under two were immunized appropriately and on time. Today this figure has risen to 87 percent."

The project was designed and implemented through a partnership with the Baptist Health System and the University of Alabama at Birmingham University Hospital in response to primary research detailing barriers to immunizations, such as inadequate staffing, wait times, missed opportunities and cost. Children and infants are immunized free each month at three locations that remain constant. These locations were selected by research and are staffed with health department public health representatives and hospital-based nurses.

When the clinics started, Jefferson County reported 58 percent of children under two were immunized appropriately and on time. Today this figure has risen to 87 percent. More than 1,500 children have been seen at these clinics.

Plans are underway to expand these clinics geographically and the program has been endorsed by city and county government, the local pediatric society and many private physicians.

More and more private physicians are referring patients to the Tot Shots Program indicating trust, recognition of public health's role in immunizations and increased communication by the private sector.

Funding Sources

• Private sources

Budget
$50,000

Partnerships

"This partnership allowed us to expand and enhance this role and identify underserved communities and an outside health partnership setting."

A community partner role had already been established by the Jefferson County Department of Health. This partnership allowed us to expand and enhance this role and indentify underserved communities and an outside health partnership setting. This project began the process of public and private partnerships in accomplishing immunization goals.

Leadership Enhanced?

Yes. This partnership has been solid because of the relationship with the 17-site county-wide immunization clinic. The goal is to immunize 1,000 children free of charge. These sites are located in private physicians' clinics.

Barriers & Strategies

Barrier 1: Lack of awareness by the community and private sector.

Strategy 1: Advertising, by direct mail to high-risk patients; fliers were posted in libraries and local retail establishments, and visits to private physicians were made.

Objectives / Data / Accomplishments

To date no specific objectives have been set. Clinic success is measured through those patients registering. The registration sheets show the number of patients coming each month and at which location. New clinics are based on health department date delinquent reports.

Program Evaluated?

Yes.

Would It Work Elsewhere?

Yes. It has proven to be a tremendous community benefit. In addition, it is a tool to use in establishing communication with the private sector.

Replicated Elsewhere?

Yes. North Alabama in late 1995.

Mobile, Alabama

Expand Maternity Center to Rural

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Initiative Categories

Perinatal Health	Access to Care
• Prenatal care • Expanding maternity services	• Reducing transportation barriers

Initiative Description

"It was also noted that many of these patients entered prenatal care late and missed appointments due to difficulty of securing transportation."

During 1995, the Mobile County Health Department initiated a secondary maternity clinic at a rural location in Mobile County. Previously, we had one large women's center near downtown Mobile, the largest perinatal provider in the county. We also had a general practice clinic in the community of Citronelle and another internal medicine clinic on an Indian reservation 12 miles from Citronelle. Neither rural location offered maternity services.

The social workers at the women's center noted that many of the maternity patients were from the Cetronelle and Indian reservation area. It was also noted that many of these patients entered prenatal care late and missed appointments due to difficulty of securing transportation. Many people from this area do not own automobiles, public transportation is not available, and unfortunately, a trip to the women's center in Mobile is usually a day-long affair.

Funding Sources

- MCH block grant funds
- Third party reimbursement (Medicaid, insurance)

Budget
$25,000

The clinic was finalized in April for opening on May 16, 1995. The clinic is open one day per week. We used the existing general practice building with an OB nurse practitioner, social worker, and existing staff to provide services. Patients receive an intake visit with lab work, social service interview and initial physical examination from the nurse practitioner. The patient must go to the Women's Center in Mobile for the second visit and be seen by an obstetrician. The physician then decides if the patient can continue receiving services from the nurse practitioner, be assigned to the high risk clinic in Mobile or a combination of the above. New equipment needed was only a fetal doppler and the clinic had the other necessary equipment. The nurse practitioner and social worker are contracted and paid for hours worked.

The patients like the clinic location and appear to be getting maternity care started earlier and keep appointments. We had 27 patients at this location during May and June, and the number of patients will grow.

Partnerships

See text...

The health department was the lead agency in conjunction with the community health center.

Leadership Enhanced?

Yes. The health department was able to take the leadership role to expand the much needed maternity services into an underserved area.

Barriers & Strategies

Barrier 1: Publicity and community involvement.

Strategy 1: Community outreach program involving both Citronelle and Indian Clinic staff. Utilize local weekly newspaper in Citronelle. Developing and posting fliers throughout the community.

Barrier 2: A rural county with a separate maternity Medicaid waiver program is located near the clinic. The new clinic is not a provider for this county.

Strategy 2: This problem has not been overcome as of this date. We have requested to become a subcontractor, but we do not utilize the same hospital for delivery. We are still trying to solve this problem.

Objectives / Data / Accomplishments

Program has specific measurable objectives, such as date entered into prenatal care and the number of prenatal visits for the new clinic patients as compared to the data for previous patients living in this census tract.

Data are collected on forms used during each visit.

The clinic started in mid-May, so we have not had time to collect data other than the number of new patients (27) that used the clinic during the past six weeks.

Program Evaluated?

NA

Would It Work Elsewhere?

Yes. If the urban community is surrounded by an isolated or semi-isolated area with indigent populations and nonexistent public transportation.

Replicated Elsewhere?

No.

Anchorage, Alaska

WIC Outreach Partnership Project

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Contact: Toni Niesen

Initiative Categories

Access to Care	Access to Care
• One-stop shopping, co-location of services	• Other outreach activities

Initiative Description

"The goal of the project was to expand the WIC caseload. The initiative focused on the relationship between the WIC program and the health department."

In response to a statewide effort to increase access to potentially eligible WIC clients, the WIC program and a section of the Department of Health and Human Services developed the WIC Outreach Partnership Project. The goal of the project was to expand the WIC caseload. The initiative focused on the relationship between the WIC program and the health department (although the state made it possible for other agencies to provide WIC services). Outreach programs have always been an integral component of the WIC program.

Expansion of outreach programming and partnerships with other organizations and satellite clinics were successful.

- one satellite clinic started in a shopping mall was expanded
- coordination of WIC services with the military, YMCA and military hospital nursing staff
- of three area hospitals, one has a weekly clinic established with an agreement to facilitate certification for newly delivered mothers and their infants at the other two hospitals
- a weekly clinic was added at the public assistance offices
- nurse case manager working with low-income, pregnant women not qualifying for Medicaid, incorporated WIC certification into the program
- WIC forms made available to the University of Alaska Health Center and Catholic Social Services

Funding Sources

- City/county government funds
- Other federal funds

Budget
$879,963

The increase in clients required more staff. The problem was solved by using Alaska Work Program and nursing student volunteers. A WIC advocate from the Health and Human Services Commission served as a liaison with nursing professional groups and coordinated services between WIC and the University.

Currently one-stop shopping exists between WIC, Family Planning, pregnant nurse case management, Healthy Mother/Healthy Baby and public health nurse home visits. The number of clients vouchered in 1993 was 49,845. In 1994 60,221 were vouchered, a 21 percent increase. Existing outreach included two satellite clinics, with one located in a shopping mall. As a future project, a WIC mobile van is being purchased and is being customized.

Partnerships

"...took the outreach initiative to hospitals and trained personnel in programs..."

The Anchorage WIC program within the Department of Health and Human Services took the outreach initiative to hospitals and trained personnel in programs to certify and recertify clients and maintain professional standards of practice. The department also worked with shopping mall administrators and provided the public assistance to set up the programs.

Anchorage, Alaska

WIC Outreach Partnership Project

Leadership Enhanced?

The Anchorage WIC program received a letter of appreciation from the state for increasing WIC enrollment. The activities continue to be a major component of the WIC program.

Barriers & Strategies

Barrier 1: Additional personnel and funds were needed to handle the increased WIC caseload.

Strategy 1: Volunteers from the Alaska Work Program, State of Alaska Department of Labor and volunteer nursing students are being used. In addition, a nutritionist from another section of the Department of Health and Human Services was loaned to WIC for five months to supervise the shopping mall expansion. Services were also received from a volunteer dietician. Vacancy factor personnel dollars were used to hire temporary staff.

Barrier 2: Programs initiated in Anchorage by the state are separated from WIC in the Department of Health and Human Services. This created an atmosphere of competition among all programs. Issues such as duplication of services, splitting families between two WIC programs and standards of practices surfaced.

Strategy 2: Not all barriers were eliminated but the programs are striving to address the major issues. A WIC brochure and a poster were designed to advertise all programs. This allowed the consumer to be knowledgeable of the various programs in the community and to make their own informed choice.

Objectives / Data / Accomplishments

The number of enrolled clients is one measurable objective. Information is collected through a statewide computer data system. In the six months since the program was initiated, participation increased 27 percent. In the past, less than 50 percent of the potentially eligible population in Anchorage received WIC benefits. As a result, this percentage increased to 68.9 percent.

Program Evaluated?

No.

Would It Work Elsewhere?

Any program or location that attracts women and children would be an excellent target site for WIC.

Replicated Elsewhere?

Don't know.

Phoenix, Arizona

Baby Mobile

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Initiative Categories

Women's Health
- Family planning

Perinatal Health
- Prenatal care

Child Health
- Immunization

Other Outreach
- Teen pregnancy

Access to Care
- Reducing transportaion barriers
- Expanding private sector linkages

Initiative Description

"This project targets clients who are pregnant or immediately postpartum, do not have access to transportation, and who see providers within a specified geographic area."

The Baby Mobile, a 15-passenger van utilized for perinatal transportation, is the result of a public/private partnership among the March of Dimes, Fry's Food Stores and the Maricopa County Department of Public Health and Community Services. This project targets clients who are pregnant or immediately postpartum, do not have access to transportation, and who see providers within a specified geographic area. The providers are from both the public and private sector. Transportation is also supplied to related sites such as WIC and AHCCCS (Medicaid) application offices, as well as for immunization and family planning appointments as time and space allow. The van is driven by an emergency medical technician certified driver. Whenever possible, appointment times are blocked by cooperating providers to allow the "Baby Mobile Ladies" to be seen in prearranged time slots to allow for more efficient use of the van. The clients' geographic pick-up locations and provider sites are also factored into the scheduling. The goal is to provide perinatal transportation to the greatest number of eligible women in an efficient, yet client-friendly manner.

Funding Sources

- City/county government funds
- March of Dimes
- Fry's Food Stores

Budget
$26,600

Partnerships

"The health department is responsible for providing the driver and coordinating clients, providers, and appointment times."

Based on history of collaborative efforts, the health department was encouraged by the March of Dimes Birth Defects Foundation (MOD) to submit a proposal for perinatal transportation. As part of the agreement with the MOD, the Baby Mobile is operated, maintained and insured by Maricopa County. The health department is responsible for providing the driver and coordinating clients, providers, and appointment times.

Pheoniz, Arizona

Baby Mobile

Leadership Enhanced?

The leadership of the health department has been enhanced by this project because it has highlighted the health department as an agency which helps link clients with minimal resources to public and private agencies so as to improve the health of themselves and their babies.

Barriers & Strategies

Barrier 1: Legal and business issues regarding who maintains ownership of vehicle, who and how the vehicle is insured, etc.

Strategy 1: A March of Dimes representative appeared in person at the board of supervisors' meeting to speak on behalf of this concept. A complex, cooperative effort resulted in clearing up this issue.

Barrier 2: Coordination of provider/client requests for service to maximize client services.

Strategy 2: We reviewed our clients' demographics, as well as incorporated ideas from the MOD. With these in mind we outlined a service area and set up a tentative schedule. Providers in these areas were contacted both by phone and through follow-up informational packets explaining the service. This has provided the basis for our runs, but we are not yet maximizing our potential. A meeting with representatives from all interested sites will be held soon to explain our service to both old and new users of the service. With personal representation, we hope to increase ridership.

Objectives / Data / Accomplishments

Records are kept regarding the number of clients transported to prenatal and related visits, as well as to the number of unduplicated providers utilized by the clients. The support staff fills out transportation request cards when clients or providers call, obtaining the client's name, address, phone, or provider's name and appointment time. The driver also maintains a "guest" log to account for not only the clients, but children and support persons transported as well. Aside from transporting approximately 40 women per month for regular visits, special activities such as transporting women to a monthly prenatal care seminar have been introduced. These women had been unable to attend previously.

Program Evaluated?

No.

Would It Work Elsewhere?

This initiative would likely work well in most communities where transportation is a barrier to prenatal care if both the health department staff and the providers are willing to put in the time, effort, and flexibility required to make this project a success.

Replicated Elsewhere?

Yes. Locally for Indian Health Service.

Los Angeles, California

Family Support Services

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Initiative Categories

Child Health	Perinatal Health
• Preconception health promotion	• Prenatal care

Initiative Description

"The county is currently developing a local governance structure which will be responsible for cross-agency and cross-system planning that addresses the needs of families."

Los Angeles County Department of Children and Family Services and The Commission for Children and Families are jointly chairing the Family Preservation and Support Planning committee. The funds from the OBRA 93 will support the ongoing Family Preservation Services and establish the Family Support Services. The planning committee has developed a county vision statement: defined "family," "community," and "family support services."

Los Angeles County has eight "service planning areas" defined by the Children's Planning Council. In these eight areas, outreach has been conducted to identify communities who will in turn identify their needs to support families.

The county is currently developing a local governance structure which will be responsible for cross-agency and cross-system planning that addresses the needs of families.

Funding Sources

- City/county government funds
- Other federal funds, OBRA 1993, Part 2 Title IV-B of Social Security Act

Budget
$36,778

Partnerships

"...district Health Officers are now beginning to collaborate with communities within their districts to participate in the planning process."

The Department of Health Services has been represented by Dr. Velasquez, Director of Child Health Programs, on the Planning Committee. In addition, district Health Officers are now beginning to collaborate with communities within their districts to participate in the planning process.

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Los Angeles, California

Family Support Services

Leadership Enhanced?

Los Angeles County has redefined public health into a of a more community orientation from a health service delivery model. This process will enable the local health officers to become involved in the communities they serve and address issues of public health through policy recommendations and planning.

Barriers & Strategies

Barrier 1: Making sure that the process is inclusive.

Strategy 1: Outreach to the community has been carefully planned, i.e., fliers, invitation and well organized meetings for the groups who agree to be involved. Personal contact was made on various strata and the meetings included a video.

Barrier 2: Drawing on all participants from counties and government agencies.

Strategy 2: The planning process was inclusive. The Board of Supervisors had made this priority with the Department of Health Services, Mental Health, Public Social Services and any other related units of the county. A strategy is being developed to include law enforcement, school districts and municipalities whose involvement has been lacking.

Objectives / Data / Accomplishments

For family support funds will be allocated, based on need in the eight service planning areas. The funding allocation is based on overall population of children and key indicators of family stress.

The allocation formula is as follows:

- 50 percent total population 0-27 years
- 8.3 percent children 0-17 below poverty level
- 8.3 percent birth to teens 10-19 years
- 8.3 percent school drop out 16-19 years
- 8.3 percent crime report
- 8.3 percent children in one parent household
- 8.3 percent foreign home population since 1970

Program Evaluated?

No.

Would It Work Elsewhere?

The most difficult problem Los Angeles County has is its size. This would easily be duplicated on a smaller scale.

Replicated Elsewhere?

No.

Oakland, California

Baby Bottle Tooth Decay Program

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Contact: Jared Fine

Initiative Categories

Perinatal Health	Adolscent Health
• Breastfeeding/ nutrition WIC	• Teen parenting
Child Health	• Teen pregnancy
• Early intervention	**Access to Care**
	• Other adult education

Initiative Description

"...is a serious, rapidly developing form of tooth decay in infants and young children which results from putting a child to bed with a bottle and constant exposure of the teeth to decay-producing liquids."

Baby Bottle Tooth Decay (BBTD) is a serious, rapidly developing form of tooth decay in infants and young children which results from putting a child to bed with a bottle and constant exposure of the teeth to decay-producing liquids. This decay can result in pain, tooth loss, infections, loss of sleep, and other serious problems. BBTD is widespread, ranging from 11.5 percent in the general population to 53 percent in rural native American children. A recent survey of Oakland Head Start children revealed a prevalence of 25 percent, thus crossing ethnic, cultural and socioeconomic boundaries.

In 1993, a local, county-wide, public/private consortium agreed to develop 1) a preventative intervention mediated by health professionals and community health workers, 2) a health outcome-based evaluation methodology, and 3) a mass media campaign. A three-hour training module was developed for pediatricians, nurses, and community health workers including an eight minute video counseling simulation, in conjunction with extensive educational materials. A new training video for dental professionals on counseling about BBTD prevention has just been produced and funds are currently being sought for adapting the module.

Funding Sources

- City/county government funds
- State general funds
- Other federal funds

Budget
$16,000

A training of trainers module was used to disseminate the program throughout Alameda County where over 100 health professionals and community health workers have been trained. The program is now being implemented in 20 other Head Start programs in Alameda County using family advocates. This outcome evaluation is designed to assess the reduction in new prevalence of BBTD within families where it has already been identified. The mass media communications campaign is being planned.

Partnerships

See text...

The role of the health department has been as a convener of the partners, a leader in seeking funding, in prioritizing this problem as a priority and in developing collaborative strategies, programmatic elements, focus groups and as manager of the process and products.

Oakland, California

Baby Bottle Tooth Decay Program

Leadership Enhanced?

The leadership of the department has been enhanced by inclusion of multiple public and private sector organizations, agencies and individuals. These include the medical and nursing community, the dental community, Head Start, WIC, Healthy Start, perinatal programs, day care providers and others. All of this has furthered the role and visibility of the department. The evaluation study has also clarified that we are committed to the health outcome measures as well as a seemingly excellent intervention.

Barriers & Strategies

Barrier 1: The first barrier to overcome was the lack of consensus among the original coalition over what approach to take in addressing the problem of BBTD.

Strategy 1: The problem was overcome by facilitating the process of letting the group come to its own conclusion. While some wanted to move ahead with patient education programs, they were supported on doing that. However, the work of finding the resources to employ in a population-based strategy required the connections and professional expertise of the department, and that leadership was expressed.

Barrier 2: The second barrier was finding additional resources to initiate the project.

Strategy 2: The problem was overcome by obtaining funds at the state and at the Federal level. A WIC nutrition intern from the local school of public health assisted in staffing the coalition. A pediatric dentist and member of the committee donated funds and obtained funds from the California Society of Pediatric Dentistry and the California Dental Association. In addition, gratis consultation was obtained from an epidemiology graduate student.

Objectives / Data / Accomplishments

The project is two part. Training objectives has increased knowledge, attitudes and willingness to counsel patients regarding the prevention of BBTD. These data are used to assess educational effectiveness at the classroom level. A follow-up survey has been conducted to assess follow through in implementation. The second aspect of the project is an evaluation of the health outcome measure, i.e., reduction in the prevalence of BBTD after the counseling intervention by Head Start family advocates. These data will be used to determine if the intervention is effective and to what degree.

Program Evaluated?

Yes.

Would It Work Elsewhere?

I think this initiative would work in other communities. It was developed as a train-the-trainer model and all the materials are self explanatory. Moreover, it is being replicated in many other cities throughout California now.

Replicated Elsewhere?

Yes. 20 other counties in California.

Santa Ana, California

All Kids Count

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Initiative Categories

Strengthening Public Health
- Building coalitions

Initiative Description

"This strategic approach was based on the belief that the right non-governmental, not-for-profit organization, could become an effective sponsor of a community partnership which focused on promoting the interests of the County's children."

In 1994, during the implementation phase of Orange County's Robert Wood Johnson Foundation (RWJ) All Kids Count project, work began to identify a local 501(c)3 organization with which to establish a long term partnership to continue the activities initiated with RWJ Foundation funds. This strategic approach was based on the belief that the right nongovernmental, not-for-profit organization, could become an effective sponsor of a community partnership which focused on promoting the interests of the county's children.

The United Way Health Care Council of Orange County agreed to establish a partnership agreement with the county to operate the All Kids Count project. The county subcontracted with United Way to continue activities for which it has received RWJ funds. United Way's responsibilities include the development of community education and marketing materials related to immunizations; supporting the Immunization Coalition; developing, implementing and evaluating immunization incentive projects; stimulating community-wide interest and participation in immunization activities; promoting the establishment of a computerized county-wide immunization registry; and soliciting financial resources to support the automated registry and related immunization activities. United Way will serve as the subcontractor for the county in carrying out local activities associated with the Immunization Assistance Project.

Funding Sources

- Robert Wood Johnson Foundation
- Immunization Assistance Project

Budget
$95,000

The County health department will continue to play an active role in all phases of the above activities. For example, the health officer is chairman of the Immunization Coalition, and local health department staff serve on the project's steering committee. Additionally, the local health department operates the automated immunization registry in order to ensure that its essential public health purposes are maintained and to protect its capacity to import data from vital records.

Partnerships

"Partnership approaches to other not-for-profit organizations failed to achieve the desired response."

The local health department assumed the lead in initiating and establishing the partnership. The process took over a year from the development concept to the actual signing of the agreement which made the partnership a reality. Partnership approaches to other not-for-profit organizations failed to achieve the desired response.

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Leadership Enhanced?

Yes. The local health department is increasingly viewed as a willing and valued collaborator with all sectors of the community. Slowly, the community is beginning to believe that partnerships and alliances involving the local health department have great potential for addressing long-standing community health problems, and it is not necessary for the local health department to always be "in control" of these collaborative undertakings.

Barriers & Strategies

Barrier 1: Suspicion that the local health department was attempting to dump on a community organization.

Strategy 1: Slowly building trust and showing resolve to make something important happen. Also, working to educate United Way leadership regarding the importance of the effort and their fundamental importance to the success of this highly valued project. The value of a collaborative relationship was slowly recognized.

Barrier 2: Acquiring sufficient funding to support the organizational infrastructure to sustain the efforts of the partnership.

Strategy 2: We transfered RWJ funds and outstanding paid County staff to the United Way and established an agreement to channel funds to United Way through a subcontract.

Objectives / Data / Accomplishments

No specific measurable objectives for this have been established. Success of this project will be considered to have been achieved if:

- sufficient capital is raised to expand the immunization registry to cover private physicians
- the Immunization Coalition remains a viable forum for determining county wide immunization policies and practices
- significant improvement in the immunization level if the County's two year olds (85 percent compliance rate) is achieved within the first 24 months of the partnership's existence

Program Evaluated?

No.

Would It Work Elsewhere?

Potentially. Success depends heavily upon the unique characteristics and resources of each community.

Replicated Elsewhere?

No.

Santa Rosa, California

Sonoma County MCAH Strategic Planning

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Initiative Categories

Strengthening Public Health
- Strategic planning for urban MCH

Initiative Description

"The 1994 planning effort identified problems and causative factors affecting our MCAH population."

In May, 1995 the Department of Health Services, Maternal Child Adolescent Health (MCAH) program and the MCAH Advisory Board co-sponsored a community-based planning effort. The 1994 planning effort identified problems and causative factors affecting our MCAH population. The 1995 session focused on the results of data collection and analysis to help specify which will positively impact this population. Over 59 public and private health and social services advocates, providers, and parents examined available health outcome data and explored their understanding of communities before coming to our meetings. At the meetings participants developed activities or actions that will improve the health of four populations: women of childbearing age, infants/toddlers, school-age children, and adolescents.

Based on the data provided and the identification of Year 2000 objectives, agencies pledged to implement one or more activities in the next year that they felt would make a significant impact on the health outcomes for the MCAH community. *Maternal:* Participants in the maternal group focused the majority of their activities on increasing women's access to prenatal care and prevention of physical abuse of women. *Infant/Toddler:* Most of the activities that the infant/toddler group concentrated on involved increasing access to well-child and immunization services and decreasing the incidence of unintentional injuries. *School-Age:* Increasing access to health services and promoting safe behaviors to prevent unintentional injuries comprised the majority of activities coming from the school-age group. *Adolescent:* The adolescent planning group participants chose activities that will change sexual and drug health awareness and behaviors of teenagers. They also focused on preventing teen suicides. Overall, actions for women, infants and children focused on increasing access to health services through expanding or increasing services and increasing awareness of services. Activities for the teen population focused more on changing health behaviors by increasing teen awareness of the issues and the services available.

Funding Sources

- MCH Block Grant funds
- March of Dimes Birth Defects Foundation, Health Plan of the Redwood, Health Net and the Kaiser Foundation

Budget
$8,045

Partnerships

"...MCAH team, WIC Director, Public Health Nurses and a child care provider worked closely over six months..."

The health department MCAH team, WIC Director, Public Health Nurses and a child care provider worked closely over six months to plan and hold this event. After preparing and distributing a written report in July 1995, a four-person team will offer technical assistance for the next 12 months as follows:

- locating other providers who may take unassigned activities
- linking agencies with appropriate resources and service models
- setting up evaluation methods to track each agency's progress
- providing baseline health outcome data
- contacting agencies quarterly for progress and providing support
- communicating progress of activities to participants

Santa Rosa, California — Sonoma County MCAH Strategic Planning

Leadership Enhanced?

The role of providing and analyzing data, facilitating community-based planning sessions, preparing a report and offering technical assistance has served to help the team in its leadership role.

Barriers & Strategies

Barrier 1: Choosing and presenting local data.

Strategy 1: The local team was able to select health outcomes using a criteria selection tool. Then matching the outcomes to Year 2000 objectives, data was gathered on a local and state basis for comparison. The team them provided the data to the community participants prior to the meetings in a work sheet presenting the overall goal, Year 2000 objectives, the comparative data on the health indicator with a brief analysis and factors that were known to impact the health outcome. The work sheet allowed space for the participant to add what he/she knew about local resources.

Barrier 2: Community polarization and choosing of activities.

Strategy 2: Receiving work sheets ahead of time participants could review data, think about factors impacting the objective and activities needed to achieve the objective. A structured process allowed each of the four focus groups to specify and prioritize these activities. In groups of fifteen, each participant was allowed to choose their best activity and it was documented. If the idea was already mentioned, they were to suggest another idea or pass. Then the group was given priority cards where they reviewed the activities in front of them and then voted for their top three. These scores were tallied and noted next to the activities.

Objectives / Data / Accomplishments

Specific measurable objectives are the selected Year 2000 objectives as they apply locally. Data was collected via many sources and this will be tracked over time. Additionally, the effort will lead us to try to formulate better data sources. The major accomplishment was to achieve a community-based effort where agencies have pledged new, innovative activities in order to achieve Year 2000 objectives.

Program Evaluated?

Yes.

Would It Work Elsewhere?

Yes. Other urban communities could use this process to undertake a community-based planning endeavor because it was fairly low cost, used resources within existing staff and depended on a fairly cooperative community.

Replicated Elsewhere?

Yes. Similar efforts in other California counties.

Stockton, California

Comprehensive Perinatal Outreach Program

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Initiative Categories

Perinatal Health	Access to Care
• Prenatal care • Low birthweight	• Overcoming cultural barriers • Increasing access to Medicaid • Other outreach activities

Initiative Description

"The primary focus was to improve perinatal outcomes through increased community awareness of the importance of perinatal care and utilization of available perinatal services."

Many factors contribute to poor birth outcomes in San Joaquin County (SJC) including high rates of inadequate prenatal care, teenage pregnancy rates, low birth rate deliveries, smoking relapse rates and smoking rates among youth. Following the enactment of California's Cigarette and Tobacco Surtax Legislation (Assembly Bill 99), the SJC Comprehensive Perinatal Outreach (CPO) Program was implemented in the Spring of 1993 to address this issue.

The program sought to provide county-wide access to perinatal care for women and infants who would not otherwise receive care. Barriers to care were addressed through media activities, a toll-free telephone line, outreach and educational activities (individual and group), enhanced service coordination and collaborative projects.

Funding Sources

- Other federal funds
- State tobacco control funds

Budget
$167,000

It is widely acknowledged that the lack of timely prenatal care varies greatly among different cultural groups and is correlated with other risk factors. Therefore, outreach and education activities targeted specific ethnic populations (African-American, Laotians, Cambodians, Vietnamese, Lao, and Hmong), as well as, teens and Medi-Cal eligible women. The diverse ethnic populations of SJC required a culturally unique approach to each ethnic subgroup identified for outreach efforts. Community Health Outreach Workers (CHOWS) representing each of the above stated ethnic groups were employed to enhance the program's aim. Outreach efforts included door to door outreach, development of community contacts, assessment of the community's needs, community group education, and development of cultural and language appropriate information to reach all of the targeted populations.

Two other target groups reached through special outreach, education and collaborative activities were "high risk/at risk" middle and high school students and incarcerated pregnant/parenting substance abusing women. .

The CPO Program bridged gaps between service providers and the community by working in collaboration with service providers and community members. Awareness of agencies providing services increased the collaboration and referrals among programs, decreased duplication of efforts and services, and increased the continuity of care.

Partnerships

"We have also been supportive by supplying meeting places, staff to set up and oversee activities, and appropriate materials to support needs."

Partnerships and collaborative activities have taken place on all levels -community, county, regional, state. CPO staff have had active roles in developing and maintaining the partnerships and planning and facilitating the activities. We have worked closely with the consultants from the State Department of Health Services. The SJC/CPO coordinator facilitated a number of regional meetings with coordinators of similar programs in other counties. Our health department played an integral part in the planning and implementing of these activities in the county and communities. Strong partnerships were developed. We have also been supportive by supplying meeting places, staff to set up and oversee activities, and appropriate materials to support needs.

Leadership Enhanced?

Yes. The increased involvement in the community through these nontraditional and culturally appropriate ways has erased some barriers and brought an awareness of the services. The commitment increased their utilization of our staff as resources and consultants on many issues (for guidance and information).

Barriers & Strategies

Barrier 1: Developing a comprehensive outreach and coordination plan for clients of target populations. Securing appropriate data to help identify needs and target populations.

Strategy 1: Developed and conducted a community needs assessment. Various data sources, reports, and program survey information was reviewed to assist with program planning. Objectives and activities of the original plan, written by the previous program coordinator, were revised to better address the perinatal needs of the county population.

Barrier 2: Lack of culturally appropriate and language specific information to educate and inform.

Strategy 2: Employed Community Health Outreach Workers (CHOWS) from the specific targeted ethnic groups. They developed or translated materials into appropriate languages and also distributed materials within the community. In-services were conducted to broaden the CHOWS knowledge base and prepare them for presenting educational topics in a variety of settings. The CHOWS were a key to developing important relationships with the community and linking them with the necessary services.

Objectives / Data / Accomplishments

A comprehensive outcome evaluation plan was designed based on measurable goals and objectives related to specific Year 2000 objectives. It was approved and monitored by State MCH Branch/Program Data and Evaluation Section. Progress reports were submitted semiannually for review and approval. Final evaluation in July of 1995.

Major Accomplishments:

- established new links between health care agencies/services and communities. Increased access.
- new collaborations have improved the referral system, reduced the duplication of services and increasedaccess to services.
- increased health care provider awareness and understanding of the communities within their jurisdiction.
- increased the communities awareness and understanding of health care issues and services. Empowered many to access services on their own.
- established a bilingual toll-free phone line for referrals to maternal, child and adolescent health services.
- provided valuable assistance to other programs, agencies and community members.
- educational materials developed, translated and distributed.
- built a cohesive team of diverse players.

Program Evaluated?

NA

Would It Work Elsewhere?

Yes. You need a community based mentality willing to serve in a manner that it wants to be served; an understanding of community needs and resources; committed staff representative of the community; flexibility; the willingness to work together, be creative and try new, nontraditional approaches; tenacity and a good coordinator.

Replicated Elsewhere?

No. Other California counties have PCO programs of their own design.

Colorado Springs, Colorado

Staff Education for Immunization Update

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Initiative Categories

Child Health
- Immunization

Initiative Description

"The Centers for Disease Control and Prevention (CDC) offered a teleconference on the Epidemiology on Prevention of Vaccine Preventable Diseases nationwide. Thirteen of our 28 staff nurses attended."

One of the main causes of low immunization levels is missed opportunities. There is a need to educate providers on what a valid contraindication is. The Centers for Disease Control and Prevention (CDC) offered a teleconference on the Epidemiology on Prevention of Vaccine Preventable Diseases nationwide. Thirteen of our 28 staff nurses attended. Video tapes of the conference were obtained and textbooks were copied with the permission of CDC. By July, 23 of our 28 nurses viewed the tapes and the remaining five are in the process. All reported an increase in knowledge and confidence in giving immunizations. The tapes have been incorporated into our orientation of new staff.

Funding Sources

- City/county/government funds
- Other federal funds (IAP)

Budget
$6,500

Partnerships

See text...

The health department has been very supportive. They absorbed the cost of copying the CDC text for the 15 staff and two clinic sites, as well as allowing time for the staff to view the videos and compensation for this time.

Leadership Enhanced?

Yes. The leadership has been enhanced. The neighboring county has asked to view and copy our videos for their staff.

Barriers & Strategies

Barrier 1: Staff set aside time for the teleconference. Those viewing the videos also set aside time but only five of the ten completed due to conflicting schedules.

Strategy 1: We are offering the videos on an individual basis. Several nurses are still in the process of viewing.

Objectives / Data / Accomplishments

Objectives:

- pretest and posttests measuring knowledge obtained by staff
- WIC immunization audits in September 1995 as compared to previous yearly audits before staff education was completed
- compare immunization rates of children up to date with recommended guidelines

Accomplishments: Staff is more confident with the importance of missed opportunities.

Program Evaluated?

No.

Would It Work Elsewhere?

Yes. Basic staff education tapes can be obtained from CDC. Due to the national success of the teleconference, another teleconference is being offered in the near future.

Replicated Elsewhere?

Don't know.

Englewood, Colorado

"A Gentle Touch" Violence Prevention

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Initiative Categories

Child Health	Adolescent Health
• Early intervention	• Violence prevention/youth at risk

Initiative Description

"It contains ten lessons that can be very easily incorporated into the standard well-child physical exam conducted at regular intervals from two weeks to five years of age."

"A Gentle Touch" is an innovative violence prevention curriculum for shaping and guiding children's behavior from birth through age five. Alarmed by the escalating youth violence in our country, two community health nurses at Tri-County observed that most violence prevention efforts target preadolescents and teens. They felt that violence prevention really should begin at birth. From this perspective, MCH providers are in the perfect position to teach new parents that the behaviors they model in the home during the formative first five years of life can have a huge impact on preventing violent behavior in children as they grow.

"A Gentle Touch" is a parenting education tool designed primarily for use in health care settings. It contains ten lessons that can be very easily incorporated into the standard well-child physical exam conducted at regular intervals from two weeks to five years of age.

The lessons provide parents with tangible violence prevention skills in area that include: gentle touching, modeling behavior, respect, being consistent, dealing with anger, setting limits, reinforcing good behavior, teaching responsibility, resolving conflict, and teaching gun safety. The kit includes master copies of skills cards to duplicate and give to parents as well as coloring pages for children. In addition, a copy of the storybook, *"Danny and the Shiny Silver Gun"* is provided with a form for ordering additional copies or a white master copy for in-house duplication.

Funding Sources

- City/county government funds
- Revenue from sales

Budget
NA

Partnerships

"...valuable input was provided by a number of organizations..."

While Tri-County Health Department is the author of the curriculum, valuable input was provided by a number of organizations that include: Rocky Mountain Center for Health Promotion and Education, Colorado Department of Public Health and Environment, Gateway Battered Women's Shelter, Colorado Department of Human Services, the Children's Hospital-Child Advocacy and Protection Team, Domestic Violence Coalition, Center for the Study and Prevention of Violence and the County Health Department.

Englewood, Colorado — "A Gentle Touch" Violence Prevention

Leadership Enhanced?

In recent years, violence prevention has begun to be recognized as a public health issue, and local health departments are beginning to join the prevention efforts. With the development of the curriculum, Tri-County Health Department is leading a movement to begin preventing violence at birth. We are publicizing the curriculum nationwide through newsletters and conferences of both health care and child welfare organizations.

Barriers & Strategies

Barrier 1: Resistance from providers toward incorporating more information and information that is not directly health-related into already busy appointments.

Strategy 1: Much of the information in the curriculum is health-related parenting information that many providers already include in their exams in bits and pieces. The curriculum mainly puts it into a context that is very relevant to concerns of today's parents, and offers materials to aid the provider in presentation. It has been tested in health care settings and found to be very easy to incorporate.

Barrier 2: Parent retention of information.

Strategy 2: The curriculum contains master copies of skills cards that providers can duplicate and send home with parents to hang on their refrigerators to aid with mastery.

Objectives / Data / Accomplishments

The effectiveness of the curriculum will be monitored at two levels. Tri-County will send an evaluation form to all agencies using the curriculum asking for their feedback on content and ease of use. This information will be applied to future editions of the curriculum.

In addition, we will distribute a parent evaluation form in our clinics to assess parent comprehension and application of the information. As the curriculum is newly published, the major accomplishments have been its completion after several years of work and beginning to get it into use in clinics around the country.

Program Evaluated?

No.

Would It Work Elsewhere?

Yes. This curriculum is designed to be implemented in health care settings in communities nationwide. It is not tailored to the Tri-County region in particular. Any local health department, clinic, or private physician's office could easily incorporate it into their exams.

Replicated Elsewhere?

No.

Lakewood, Colorado

Improving Prenatal Care Using TQM

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Initiative Categories

Perinatal Health
- Prenatal care

Initiative Description

"TQM measures "quality" in health care as "access" to care, "appropriateness" of care and "acceptability" of care as perceived by our consumers."

This project demonstrates that Total Quality Management/Continuous Quality Management Improvement (TQM/CQI) is a successful approach to assure that prenatal services are meeting the needs of our consumers.

TQM measures "quality" in health care as "access" to care, "appropriateness" of care and "acceptability" of care as perceived by our consumers.

The goal of this committee was to improve consumer satisfaction by: improving access and coordination of prenatal care, reducing duplication of services and by improving pregnancy outcomes by reducing our low birth rate. This committee consisted of representatives from every program that served prenatal clients. A prenatal client flow chart was developed to map client's steps throughout our various prenatal services. Also, client and staff surveys were conducted to gather data about their perceptions of our services.

Areas of improvement were identified and changes implemented to improve services and meet the goals of the committee.

Funding Sources

- City/county government funds

Budget
$3,500

Partnerships

See text...

TQM shifts measuring quality care from chart audits to consumers' perceptions and expectations of services. This approach also involves managers and staff in a proactive approach to make changes to improve programs.

Lakewood, Colorado

Improving Prenatal Care Using TQM

Leadership Enhanced?

TQM provides a model that empowers staff to identify areas that need improvement and to develop strategies for change.

Barriers & Strategies

Barrier 1: Resistance to a new approach for evaluating services.

Strategy 2: Training managers and staff in TQM and assisting in the implementation of this process. This was also overcome through identifying successes.

Barrier 2: Constant change in committee members.

Strategy 2: Eventually identified a core of committee members that were vested in this process.

Objectives / Data / Accomplishments

Fiscal impact savings of staff time:

Reduction of two history/intake forms:	$ 8,000
Increase access to charts	$21,000
Decrease duplication of referrals	$3,000
Decrease of inappropriate referrals	$750
Total Savings:	$32,750

Program Evaluated?

Yes.

Would It Work Elsewhere?

Yes. TQM is being initiated in the health care industry and is a national trends for improving quality of services in the private sector.

Replicated Elsewhere?

Yes. Denver hospitals.

Wilmington, Delaware

Home Visiting For First Time Parents

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Initiative Categories

Perinatal Health
- Home visiting

Child Health
- Early intervention

Access to Care
- Expanding private sector linkages
- Case management

Adolescent Health
- Teen parenting

Strengthening Public Health
- Building coalitions

Initiative Description

"This voluntary program assesses medical and parenting needs, links parents to a comprehensive range of services, promotes self sufficiency in service use, identifies service gaps in the community."

Supported by the Delaware's Governor and his Family Services Cabinet Council, a public-private, multi-agency committee, the Parent Education Partnership (PEP) recommended Home Visiting for all first time parents to provide a cost-efficient continuum of parent education and support services. Phase I of the Home Visiting Program was established in an economically impoverished area of the City of Wilmington, designated as the Enterprise Community.

This voluntary program assesses medical and parenting needs, links parents to a comprehensive range of services, promotes self sufficiency in service use, identifies service gaps in the community. Extensive involvement of stakeholders - parents, community leaders, medical providers at the birthing facilities, home health agency staff, and parent education providers - has produced a foundation that is community based and community "owned". Existing services have been organized into a network of comprehensive services.

Funding Sources

- General state funds
- MCH Block Grant funds
- Other federal funds
- Part H CISS grant
- Medicaid insurance

Budget
$350,000

The role of public health is to assure there is a smooth running, efficient, and family-friendly program that provides outreach, early identification of families at risk, family assessment, and service coordination. Public Health worked with the hospital and providers of home visiting services to set standards, assess program impact and monitor health outcomes. Contractual arrangements are made with all involved agencies.

Designated staff at the hospitals (discharge planners or social workers) referred first-time parents living within the Enterprise Community to the home care agency of their choice. The home health nurse assessed the medical condition and immediate needs of the family and helped to link parents to services to meet the identified needs. If needs were identified which could be addressed by one of the parent support agencies the nurse made a referral to that agency. The parent support agency would do a broader assessment of family needs and determine with the family what, if any, further services were needed and provide those services or refer to another agency.

Partnerships

"...public health's role was to provide the framework and practical application for implementation of this concept."

As a leadership member of PEP, public health's role was to provide the framework and practical application for implementation of this concept. Public health was recognized as having extensive home visiting experience, knowledge of the community and the needs of young families.

Wilmington, Delaware — Home Visiting For First Time Parents

Leadership Enhanced?

As a result of the development of this project, Public Health has become more visible to community leaders and agencies, and new, stronger links have developed with the City of Wilmington and New Castle County, in addition to community agencies.

Barriers & Strategies

Barrier 1: Insufficient personnel resources allocated for phase I.

Strategy 1: Insurance and Medicaid paid for most of the first home visits, but the coordination and program development were carried out with existing resources within Public Health and participating agencies. Frequently, it was a "beg, borrow, and steal" situation to accomplish our goals. Even basic equipment, such as computers, had to be borrowed.

Barrier 2: Working within a multiagency framework brought forth concerns of sharing between agencies who were used to competing for resources: worries about losing their ideas, materials, or protocol to competing agencies, concerns of sharing information, etc., as well as additional paperwork requirements.

Strategy 2: Strong, savvy leadership brought gradual development of trust, and agencies eventually saw the potential rewards, such as assistance in reaching clients who they might not have otherwise reached, etc. Many community meetings, focus groups and input from the community allowed the "ownership" necessary to succeed.

Objectives / Data / Accomplishments

An evaluation plan has been developed with the assistance of the University of Delaware and Delaware State University, although resources are scarce which will limit scope of the evaluation. Application for a technical assistance grant has been completed. Data on demographics, services and agencies, as well as service gaps, have been collected using the Integrated Services Information System (ISIS). Parent satisfaction surveys have indicated a high level of satisfaction, and parents have expressed that the program has really helped them by answering their questions and providing caring support.

In the Enterprise Community, the majority of parents opted to continue to receive services after the first visit. There has been a high level of cooperation and collaboration within the participating agencies and the efforts put into building community support have been an invaluable investment and will hopefully play a role in the long-term sustainability of this program.

Program Evaluated?

In progress.

Would It Work Elsewhere?

Yes. It involves all key stakeholders in your community, focusing on the overall goal of providing support to new parents for the healthy development of their children and actively working to build the partnership.

Replicated Elsewhere?

No.

Washington, D.C.

DC Healthy Start Male Outreach Workers

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Initiative Categories

Access to Care
- Increasing social support systems
- Case management

Strengthening Public Health
- Building coalitions

Other
- Job training

Initiative Description

"...focus on education, outreach, referral, support groups and monitoring directed toward behavioral changes and the development of personal responsibility, personal/family interaction skills, and preparation for responsible parenthood."

The DC Healthy Start Project, under the office of MCH, further strengthened outreach to males by fielding 12 adult male outreach workers and a supervisor. Initiated in August 1994, the male outreach workers (MOW) underwent six-weeks of intensive training which included canvasing and community male surveys. The MOWs provided case management and support to project area males.

The program's efforts focus on education, outreach, referral, support groups and monitoring directed toward behavioral changes and the development of personal responsibility, personal/family interaction skills, and preparation for responsible parenthood.

During the period of September 1994 through February 1995, the MOWs managed a caseload of 89. They made 1,300 telephone and 65 personal contacts. They assisted and managed to acquire employment for 13 males.

Funding Sources

- Other federal funds

Budget
NA

Partnerships

See text...

The office of MCH through this effort built linkages with organizations that provided services to males.

Washington, D.C.

DC Healthy Start Male Outreach Workers

Leadership Enhanced?

Traditionally seen as involved only with maternal and child issues, this activity has enhanced the leadership of the project in family issues.

Barriers & Strategies

Objectives / Data / Accomplishments

This initiative fits in with several of the DC Healthy Start project objectives. Data are collected within the overall project data and are closely monitored. The MOW "players" members of the program perform theatrical presentations at the community centers, churches and area schools. Skits are written by them using real life situations. Audience interacts with the "players" in discussing situations.

Program Evaluated?

No. This initiative will be evaluated as part of local evaluation.

Would It Work Elsewhere?

Yes. There are males in every community who are committed and who need a chance to be empowered to set a personal goal and find ways to reach that objective.

Replicated Elsewhere?

Yes. There are other male outreach programs in other cities and states

Jacksonville, Florida

Teen Connect

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Initiative Categories

Women's Health
- Family planning

Access to Care
- Expanding private sector linkages

Strengthening Public Health
- Building coalitions

Perinatal Health
- Low birthweight/ infant mortality

Adolescent Health
- Teen pregnancy
- Teen parenting

Initiative Description

"The program provides an immediate postpartum intervention for teenage mothers and their infants and intensifies the support and resource network available to teen parents."

To reduce births to teenage mothers and decrease infant mortality, the Duval County Public Health Unit implemented Teen Connect February 1, 1995. The program provides an immediate postpartum intervention for teenage mothers and their infants and intensifies the support and resource network available to teen parents.

Upon delivery in two major hospitals, the records of teenage mothers are flagged. The mothers receive the routine family planning/birth spacing, in-hospital visit by a public health nurse at which time the mother is given the opportunity to discuss contraceptive methods and is started on a form of birth control. An immediate referral is then sent to the Healthy Start Care Coordination Team to make a home visit within the first week of discharge.

A case management plan is completed, and visits and referrals are accomplished by an assigned Care Coordinating Team consisting of a public health nurse, a social worker and a family support worker. Referrals are completed for pediatric care including WIC and immunization services, social services, mental health counseling, and parenting education. In addition, mothers may attend infant safety classes to obtain a car seat and are assisted in obtaining other baby items through community sources. The Healthy Start Program follows infants up to age one year.

Funding Sources

- City/County Government Funds
- State of Florida Healthy Start Funding

Budget
NA

Although open to all teenage mothers, the target population is in the core city where teenage birth rates exceed and, in some zip codes, nearly double the national average of 62.1 per 1,000 births. In the first six months, 122 teenage mothers have been supported.

Starting in the fall of 1995, Teen Connect will become a component of the Maternal and Child Health Five-Year Plan for Duval County/Jacksonville. The plan builds upon several initiatives in place to improve the health status of infants and mothers in a specific geographical area of the city. The seven zip code area is the implementation site of a State of Florida Healthy Community, Healthy People project, a CDC lead prevention project, and a broad-based community effort that includes the State of Florida's Healthy Start Program and the Jacksonville Children's Commission. The partnership with the Children's Commission extends childrens resource visits up to age five.

Partnerships

"...the role will be as facilitator and partner."

The health department as part of its MCH program and as the contact agency for the Healthy Start program assumed the leadership role. As part of the overall Maternal and Child Health five year plan, the role will be as facilitator and partner.

Leadership Enhanced?

Yes. Ultimately, the local public health department is looked upon as the responsible entity for infant and maternal child health status. This effort emphasizes the service assurance role.

Barriers & Strategies

Barrier 1: Care coordination tracking and feedback to all parties.

Strategy 1: The Maternal and Child Health Five Year Plan will provide intensive computerized tracking and a shared data base. In addition, resources will be leveraged by intensifying cooperative efforts to provide continuing support to the teenage mother. Additional community networking will allow more time for staffing of priority cases.

Barrier 2: Resources both in terms of funds and staff for evaluation of efforts.

Strategy 2: Rigorous process and outcome objectives and methodologies are included within the Maternal and Child Health Five-Year Plan to assist in overcoming this barrier. Plans are to pool resources to provide professional evaluation.

Objectives / Data / Accomplishments

Specific, measurable objectives are included in the Five-Year MCH Plan. Data for outcome indicators and for monitoring will be collected on a computerized tracking program at the public health unit. The major accomplishments to date include the streamlining of the referral process from the on-site hospital team to the care coordination team. Also, 122 teenagers were counseled and started on a contraceptive method.

Program Evaluated?

No.

Would It Work Elsewhere?

Yes. Especially if partnership exists for the support of teen mothers. A national priority is to reduce births to adolescents and this effort can provide an immediate contact to provide support during the critical post partum period and the first year of life for the infant.

Replicated Elsewhere?

No.

Miami, Florida

Adopt-a-School

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Initiative Categories

Adolescent Health	Adolescent Health
• School-linked school-based services	• Schools and school health connections • Expanding private sector linkages

Initiative Description

"...encouraging local and private partners to adopt neighborhood schools."

The School Health Program in Dade County is expanding rapidly. As the need for comprehensive school health services becomes greater, and human resources remain limited due to funding constraints, the community at-large has become involved in school health services delivery. The Greater Miami Chamber of Commerce has taken the lead, together with Dade County Public Health Unit and Dade County Public Schools in encouraging local and private partners to adopt neighborhood schools. In the initiative, a partner may opt to sponsor a nurse, social worker or paraprofessional for a particular school. If the partner is a health care provider, they most often "donate" an existing staff member. A nonhealth related business contract directly with the department to hire the staff member. Partners may choose any combination of models and are encouraged to choose schools in areas with limited access to health care and/or a neighborhood school.

This project is a "win-win" solution for everyone. The students receive services and the community takes pride of ownership in its most precious resource, the children.

Funding Sources

• Private sources

Budget
$175,000

Partnerships

"The school health managers facilitate all aspects of the Adopt-a-School program."

The DCPHU has taken the lead in planning, implementing and evaluating the program. Most importantly, the school health management team provides the quality assurance and improvements. School health supervisors conduct preservice workshops, ongoing staff development and on-site clinical supervision. The school health managers facilitate all aspects of the Adopt-a-School program. The department of Volunteer Services contributes greatly by providing the necessary documentation to grant partners with sovereign immunity.

Miami, Florida

Adopt-a-School

Leadership Enhanced?

The leadership of the health department has most definitely been enhanced by the Adopt-a-School Program. The DCPHU school health management team together with the support of administration and physician services, has emerged as an advocate, facilitator, mentor and community leader. The DCPHU is perceived in a positive, nonpunitive manner while still assuming the critical role of quality assurance.

Barriers & Strategies

Barrier 1: Space in schools to accommodate Adopt-a-School staff.

Strategy 1: Despite the great needs and schools' enthusiasm, often terribly overcrowded schools are unable to house staff appropriately. This was overcome by careful selection and screening of schools to insure adequate space and by consistent meetings with those concerned. Persistence and flexibility.

Barrier 2: Fear of "turf" protection.

Strategy 2: Fortunately, this never materialized into a problem. There were doubters that feared public and private would not "mix" well. However, this has never been the case. A great deal of time was invested initially in role clarification, and the spirit of cooperation was embraced. True collaboration is definitely tedious, but the results are well worthwhile.

Objectives / Data / Accomplishments

This initiative shares the same objectives and data collection process as the DCPHU nurses in the basic school health program. The major objectives are:

- to improve student health
- to reduce teen pregnancy
- to reduce risk factors such as substance abuse, injury, nutritional problems, HIV/STD. Additionally, a goal for the Year 2000 is to see a nurse in every school.

Data are collected through a newly computerized tracking system and recorded monthly. Analysis is ongoing and changes are made accordingly.

Program Evaluated?

No.

Would It Work Elsewhere?

Most likely this initiative would work in any urban community, provided that the infrastructure exists to provide oversight, and that community leaders, school system and health department leaders are proactive, not turf-guarding.

Replicated Elsewhere?

No. State health office is exploring a statewide project.

St. Petersburg, Florida

Healthy Start Drug Involved Families

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Initiative Categories

Perinatal Health	Child Health
• Expanding maternity services • Home visits • Low birthweight • Substance abuse prevention	• Early intervention • Expanded child health services

Initiative Description

"...is providing county-wide intensive care coordination services to prenatal mothers needing substance abuse services and newborns who are substance exposed."

With the help of the Pinellas Health Start Coalition and a multiagency collaborative partners approach, the Healthy Start Drug Involved Families Pinellas Program (DIF) is providing county-wide intensive care coordination services to prenatal mothers needing substance abuse services and newborns who are substance exposed. Collaborative partners for the program include Ounce of Prevention, the Juvenile Welfare Board, Bayfront Medical Center, Sun Coast Hospital, Operation PAR, Step Ahead, and Project Independence under the leadership of the Health Department.

The DIF provides family-centered support planning, referrals and linkages to needed community services and child development education through home visits by family support workers (FSW). The FSW are trained in the Healthy Families America home visiting approach. Healthy Families America is a national organization supporting families throughout the country. The family support plan is the guiding document for assisting families to identify their own needs and goals for future family building. The FSW leads families to healthy life styles by empowering families to connect to informal and formal supports in their communities.

Funding Sources

- City/county government funds
- General state funds
- In-kind scholarship for drug treatment

Budget
$890,508

The DIF program in Pinellas County is supervised by Senior Community Health Nurse Specialists who offer specialized training and experience in working with drug-involved families. An additional collaborative component to this unique program is the addition of a social worker at the Bayfront Medical Center prenatal clinics who provides early identification of substance abusing pregnant women beyond the scope of the Healthy Start screening by completing psychological assessment as part of the routine prenatal care. A third component of this program is the addition of two Women Intervention Specialists (WIS) who complete substance abuse assessments in the homes of identified drug involved families to increase the chance of engaging families into treatment when needed. These WIS are part of the community partners efforts to tailor this program to the individual makeup and needs of the local community.

Partnerships

See text...

Leader in bringing other community partners to form a team, with bringing three funders together to agree to fund one part but look at the program as a comprehensive program county-wide.

Leadership Enhanced?

Yes. In the environment of competitive managed care, the health department is viewed as a neutral non-competitive agency, and as such has been able to bring together hospitals, drug treatment programs to form a multi-disciplinary, multi-agency team.

Barriers & Strategies

Barrier 1: Lack of funding.

Strategy 1: The initiative is funded by three grants from three different funders (Ounce of Prevention/Juvenile Welfare Board of Pinellas County/Healthy Start Coalition, Inc., Pinellas County/and in-kind from agencies).

Barrier 2: Different reporting period and format for funding agencies for same program.

Strategy 2: Initiated a work group between three funders and the health department and convinced them to accept same reporting. They compromised and we were able to agree on one single comprehensive, quarterly report.

Objectives / Data / Accomplishments

Outcome objectives:

- 85 percent of the participants will not be involved in a confirmed report of abuse or neglect
- 60 percent of newborns of participating women will deliver normal birthweight infants (5lbs 8oz +)
- 90 percent of all infants will be up-to-date for age immunization
- 70 percent of program participants for six months will have involved themselves in some type of self-sufficiency program
- 50 percent will sustain healthy lifestyle changes and remain substance free

Collection of target population data:

- computerized case management system
- data consists of profiles, services, referrals, medical tracking and assessment tracking

Outcome and process objectives:

- participants receiving home visiting, prenatal care, family support planning, substance abuse, etc.
- infants at normal birthweight, improved bonding, up-to-date immunizations, confirmed abuse/neglect.

Number of participants:

- in self-sufficiency programs, remaining substance free after treatment, satisfied with program

Program Evaluated?

Yes.

Would It Work Elsewhere?

Yes. Prevention and early intervention for drug involved families is needed in many communities. The problem can only be solved if the local community is involved. A partnership model is key strategy.

Replicated Elsewhere?

Unknown.

Boise, Idaho

VISTA / Immunization Tracking & Recall System

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Initiative Categories

Child Health	Strengthening Public Health
• Immunization	• Immunization tracking, recall systems

Initiative Description

"Each district contracted to have VISTA volunteers work with the immunization program in developing coalitions, incentives and awareness programs."

VISTA volunteers are in service to America. There are seven health districts in Idaho and Central District Health is one of those. Each district contracted to have VISTA volunteers work with the immunization program in developing coalitions, incentives and awareness programs. These volunteers have worked with service groups, state immunization staff, clients and the medical community to raise the awareness of needed immunizations for children less than 24 months of age.

Immunization Tracking & Recall Systems: A computer system has been implemented which is networked to private providers in the district. This network includes a health department immunization repository so other providers can connect by modem for look-up and add-to rights. This system offers better client services because of the opportunity for immunization record verification and the ability to assess immunization levels of the community. This is a tracking and recall system for children less than seven years of age.

Funding Sources

- City/county government funds
- Other federal funds
- Private sources (Rotary)

Budget
$8,864 (VISTA)
$6,780 (tracking & recall)

Partnerships

See text...

VISTA for funding support. The Health District provides supervision, physical location, and financial assistance.

Immunization Tracking & Recall Systems: Central District Health Department was the initiator to market the concept to other service groups and the medical community.

Boise, Idaho

VISTA / Immunization Tracking & Recall System

Leadership Enhanced?

Yes. With enthusiastic, innovative young people working in this area it has allowed for innovative ideas and higher community visibility. Immunization Tracking & Recall Systems: Central District Health Department was definitely the "push" behind this district-wide network. Greater visibility in working with private partners and community service groups.

Barriers & Strategies

Barrier 1: Finances.
Strategy 1: VISTA: Obtained grant for partial funding. Obligated district funds for remaining needs. Immunization Tracking & Recall Systems: Sought private funds and cooperation of other health care providers.

Barrier 2: Immunization Tracking & Recall Systems: Selection of computer software.
Strategy 2: Before final selection, we assessed and evaluated several software products that would best meet district and private provider needs.

Objectives / Data / Accomplishments

Yes. There are measurable objectives. Data collection is by compiling events and numbers of persons served. Major accomplishments: VISTA - developed a slogan and logo for immunizations: "Vaccinate The GEM State - Immunize your little GEMS". (Idaho is the Gem State). Developed a T-shirt for sale. Immunization Tracking & Recall Systems: Computer network includes the hospital which delivers a majority of babies, pediatric groups, one residency program and the health department.

Program Evaluated?

No.

Would It Work Elsewhere?

Yes. For both the Immunization and Immunization Tracking & Recall System. These are concepts which are tangible and can have short-term and long-term goals. They utilize community resources and a nationwide program which can be accessed by others.

Replicated Elsewhere?

Yes. Throughout the state of Idaho for the VISTA Program. The Immunization Tracking & Recall System computer software is being looked at by other health districts throughout Idaho. This software program is one which is being used in other states such as Texas, Nevada and the state of Washington.

Chicago, Illinois

Weight Gain and Pregnancy Initiative

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Initiative Categories

Perinatal Health
- Prenatal care
- Low birthweight/ infant mortality
- Breastfeeding/ nutrition/WIC

Access to Care
- Expanding private sector linkages

Strengthening Public Health
- Staff training
- Building coalitions & partnerships

Initiative Description

"Through this initiative, the problem of low birthweight will be addressed by encouraging pregnant women to gain adequate weight during pregnancy."

The Weight Gain in Pregnancy Initiative is a demonstration project whose purpose is to provide enhanced prenatal services to the residents of the Englewood and West Englewood communities. Englewood and West Englewood are listed among the communities with the highest need for maternal and child health (MCH) services in the city of Chicago.

Through this initiative, the problem of low birthweight will be addressed by encouraging pregnant women to gain adequate weight during pregnancy. Women who gain inadequate weight during pregnancy (less than 25 pounds) are two and a half times more likely to have low birth weight babies. Two of every three infants who died in Englewood and West Englewood in 1992 were classified as low birthweight. The goal of this initiative is to decrease the incidence of inadequate maternal weight gain among project participants.

The intervention is divided into two parts. Phase I. of the intervention is aimed at providing in-service training on the current recommended weight gain in pregnancy standards to the Chicago Department of Public Health (CDPH) staff and community based primary care providers and their staff. Phase II of the initiative is an intensive, nutritional behavior intervention targeting prenatal patients at Englewood Neighborhood Health Center (ENHC) and those receiving obstetrical care at selected community sites.

Funding Sources

- MCH Block Grant funds

Budget
$168,000

Delivery of this intervention is based on a multidisciplinary team concept. The team seeks to provide comprehensive prenatal care in a setting which conveys consistent messages about appropriate weight gain and nutrition during pregnancy.

CDPH will seek to determine if prenatal weight gain is enhanced by the following interventions with patients: 1) a passive media campaign; 2) individual motivational messages; 3) assessment, routine monitoring and follow-up, nutrition counseling, social support, and referrals to resources such as WIC and emergency food resources; 4) creation of an environment that is conducive to good nutrition; 5) and strategies to enhance the provider's skills and knowledge.

Partnerships

"A key component of this initiative has been to encourage the community to take ownership of a major public health care problem (infant mortality) and to collaborate in its resolution."

CDPH has provided training, resources, technical assistance and information to public and private health care providers and to the community. Our efforts have been to assess the needs of the community and to support preexisting services while helping to supplement service gaps. A key component of this initiative has been to encourage the community to take ownership of a major public health care problem (infant mortality) and to collaborate in its resolution.

Chicago, Illinois

Weight Gain and Pregnancy Initiative

Leadership Enhanced?

The Weight Gain in Pregnancy Initiative has added another dimension to the community's perception of the CDPH. Posttraining feedback has been very positive. Health care participants stated that they would like the CDPH to conduct more training on both MCH as well as other health care topics. There has also been an increase in requests for in-service and training by nonmedical groups (i.e., social service agencies and schools) who want to incorporate the initiative's message into their programming.

Barriers & Strategies

Barrier 1: Knowledge deficit of health care staff about appropriate nutrition and weight gain during pregnancy.

Strategy 1: Health care staff were surveyed on their attitudes, knowledge and beliefs about weight gain and pregnancy. Based on their responses, a training program was developed and has been implemented. Participants included CDPH and community providers and staff who care for prenatal patients. The training included current recommendations and protocols on weight gain and strategies for nutrition education and counseling of pregnant women.

Barrier 2: Difficulty coordinating training for community providers due to time constraints.

Strategy 2: Onsite training of community-based providers and their staff had been conducted for those with scheduling conflicts. Support staff at these sites were helpful in identifying appropriate times in their clinic schedules.

Objectives / Data / Accomplishments

Measurable objectives include decreasing the percentage of low birthweight infants who are born to ENHC patients; decreasing the percentages of low birthweight infants who reside in the Englewood and West Englewood Community areas respectively, and; increasing the percentage of women who gain between 25 to 35 pounds during their pregnancy.

We have started to document the number of prenatal visits and the title of the health care team member who provided services to the patient. We hope to determine the effect of having a multidisciplinary health care team deliver the same message on prenatal weight gain. The second part of the analysis is to match the pregnant women with their infant's birth certificate to determine the infant's birth outcome.

- 900+ pregnant women received consistent messages on prenatal nutrition & weight gain
- 46 percent increase in staff recommending proper weight gain ranges
- a culturally sensitive pamphlet & poster to deliver weight gain message at various locations
- CDPH developed nutrition protocols adopted by our public and private partners in this initiative
- eight public & private providers have agreed to implement the initiative in their setting
- two providers have already started full implementation which includes data collection.

Program Evaluated?

No.

Would It Work Elsewhere?

Yes. The delivery of comprehensive quality health care and nutrition services to reduce the incidence of negative birth outcomes is a concept that anyone offering MCH services could adopt. CDPH has developed a number of strategies that may be useful in making an impact on prenatal care, nutrition, infant morbidity and infant mortality.

Replicated Elsewhere?

No.

Peoria, Illinois

Nutrition Aid Home Visiting WIC

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Initiative Categories

Perinatal Health
- Expanding maternity service
- Home visiting
- Breastfeeding/ nutrition/WIC

Access to Care
- Other outreach activities

Initiative Description

"...to teach and reinforce feeding techniques, to promote and support breastfeeding, to instruct and supervise in formula preparation, and to act as a liaison between the clinic nutritionists and WIC..."

Early hospital discharge, lack of or inadequate support systems in the home for mothers, and a growing WIC caseload which limited the amount of time for home visits by WIC clinic nutritionists, promoted the Peoria City-County Health Department (PCCHD) to institute a home visiting program. Purposes of the program are to teach and reinforce feeding techniques, to promote and support breastfeeding, to instruct and supervise in formula preparation, and to act as a liaison between the clinic nutritionists and WIC clients in their homes following up on formula or feeding problems identified by nutritionist during later clinic visits.

Each WIC mother followed prenatally receives a "For Baby" form which her physician fills out at delivery addressing specific feeding needs of this infant. It is then mailed to PCCHD and the nutrition aide schedules a home visit, within one to ten days of hospital discharge. An additional benefit to some clients is an early link to service of case managers in our Healthy Moms/Healthy Kids program. thereby leading to early intervention and conflict resolution in many cases.

Funding Sources

- City/county government funds
- Other federal funds

Budget
$41,000

Partnerships

See text...

This was a need identified by program staff and middle management based on client/program needs.

Leadership Enhanced?

Yes. It has promoted our position in collaborative efforts with other programs as well as community agencies since the nutrition aide service is included when we jointly share clients with other agencies and collaborate with for service delivery.

Barriers & Strategies

Barrier 1: Training, job description and identifying performance expectations for a paraprofessional.

Strategy 1: Nutritionists designed training and expectations in conjunction with middle management.

Objectives / Data / Accomplishments

Yes. Collected data on number of home visits and clients served. Data has yielded information about the importance of support systems for new mothers. We feel benefits to clients are great and will pursue data about client satisfaction.

Program Evaluated?

No.

Would It Work Elsewhere?

Yes. All urban communities share the same problems in their MCH populations identified as need by Peoria City-County Health Department.

Replicated Elsewhere?

NA

Evansville, Indiana

Child Health Network

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Initiative Categories

Child Health
- Expanded child health services

Access to Care
- Expanding private sector links

Strengthening Public Health
- Building coalitions & partnerships

Initiative Description

"These clinics provide preventive care and limited illness care to children ages two months to 19 years of age on a sliding fee scale based on household income."

Vanderburgh County Health Department supports three Maternal Child Health Clinics (CHC). These clinics provide preventive care and limited illness care to children ages two months to 19 years of age on a sliding fee scale based on household income. Approximately 65 percent of these clinics are in a zero percent pay category, and most of these are underinsured or uninsured.

The CHCs are open 8 am - 5 pm Monday through Friday. Because of these hours, no medical coverage was available after regular clinic hours. Two of our clinics are staffed by pediatric nurse practitioners and three third clinic is staffed by a pediatrician who works under contract 20 hours per week. Two of the local hospitals and one clinic that is associated with a third hospital are providing medical coverage after hours, weekends and holidays for the CHCs. The two hospitals have family practice residency programs that provide coverage and the third clinic is covered by the pediatric department of a local HMO.

All three health networks also provide medical coverage during clinic hours if children need to be seen by a physician and/or admitted to the hospital. Children who don't have a primary care physician are enrolled in the Child Health Network and given a card that identifies them as such. They are given instructions on how to access medical care after regular clinic hours. Charges for medical services rendered by these three entities are also based on the sliding fee scale that was established at the CHC.

Funding Sources

- City/county government funds
- MCH Block Grant funds

Budget
In-kind services

Partnerships

See text...

Since the health department sponsors the three CHCs, this collaboration was planned and implemented by the clinic staff. The medical director of the health department is responsible for signing contracts between the health department and the three medical providers.

Evansville, Indiana

Child Health Network

Leadership Enhanced?

The greatest accomplishment through this initiative has been the increased collaboration between the health department and the three hospitals in Vanderburgh County. The medical community is now more aware of the increasing number of children who are uninsured or underinsured in their community and are taking an active role in helping to provide the much needed medical care for these children.

Barriers & Strategies

Barrier 1: Staff changes, especially in the two hospital residency programs, result in clients reaching medical providers after clinic hours who are not aware of how the Health Network system works.

Strategy 1: Staff education, especially with new residents, is done at least yearly and when changes are implemented. Meetings are set up at least two times a year for the CHC staff and their medical provider in the Child Health Network to discuss procedures and problems of the joint effort.

Barrier 2: The occasional lack of communication between CHC and the medical provider results in our staff not knowing when one of our clients has been seen after hours and what follow up is needed.

Strategy 2: A one-page consultation form with pertinent medical information about the child was developed to be faxed to the medical provider. They will then fill out the form after seeing the child and send it back to the clinic for appropriate follow-up and to be filed in the child's chart.

Objectives / Data / Accomplishments

The main objective in this initiative has been to decrease the number of children being seen in the emergency room for nonemergency illnesses. This can mean a savings to the hospital and to the client because so many of these children don't have insurance, and the hospital ends up absorbing the cost of these visits. We have set up a computer program to monitor the number of children being enrolled in the three networks. Each hospital and pediatric clinic collects data on the number of children actually being seen through their individual clinics. The major accomplishment in this initiative was having the third hospital/clinic sign a contract with one of our clinics. Now, all of the hospitals are involved with the health department and with this initiative. All of the children enrolled in our clinic now have access to medical care 24 hours a day.

Program Evaluated?

No.

Would It Work Elsewhere?

Yes, with good communication and collaboration among all parties. The medical community should be educated on the number of uninsured children that are unable to access affordable medical care in their community. This initiative not only decreases overall medical costs but increases the medical care available to the targeted population.

Replicated Elsewhere?

No.

Gary, Indiana

Prenatal Substance Use Prevention Program

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Initiative Categories

Perinatal Health
- Prenatal care
- Low birthweight/ infant mortality
- Substance abuse prevention

Adolescent Health
- Teen pregnancy

Access to Care
- One stop shopping

Strengthening Public Health
- Staff training

Initiative Description

"In addition to client education, PSUPP is involved with educating the community on the dangers of substance use during pregnancy."

Prenatal Substance Use Prevention Program (PSUPP) is a multi-level prevention, intervention, and referral program designed to prevent poor birth outcomes due to tobacco, alcohol, and street drug use during pregnancy. The program director does a substance use assessment on clients at their initial visit to the clinic.

PSUPP uses one-on-one interaction as well as group education. In addition to client education, PSUPP is involved with educating the community on the dangers of substance use during pregnancy.

PSUPP works as the liaison between prenatal clinics and the treatment centers. PSUPP provides on-site smoking cessation programs and classes for prenatal clients.

Funding Sources

- Other federal funds

Budget
$49,220

Partnerships

See text...

The Gary Health Department has allowed PSUPP to participate in all health department promotion activities. The program is included in health department literature. The health department has been instrumental in securing meeting space for training activities.

Gary, Indiana — Prenatal Substance Use Prevention Program

Leadership Enhanced?

PSUPP is a county-wide program and the only one of its kind in Lake County, Indiana. The activities of PSUPP have made the Gary Health Department well-known among other service providers in the community.

Barriers & Strategies

Barrier 1: Gaining access to local hospital prenatal clinics.

Strategy 1: This barrier was overcome by a series of meetings with several administrative staff members from the hospital. The program was thoroughly explained. It was made clear that by adding the PSUPP component to their prenatal clinic would not increase the work load of their present staff. The benefits of having an outside person access prenatal clinics for substance use was presented. Perhaps the most influencing factor was that PSUPP has working agreements with local treatment centers for accepting referrals.

Barrier 2: Networking with other service providers.

Strategy 2: This barrier was overcome by the PSUPP director joining a network of treatment and prenatal providers. PSUPP works very closely with Healthy Start, a county initiative aimed at reducing infant mortality. This allowed PSUPP to come in contact with those persons that service pregnant women.

Objectives / Data / Accomplishments

The measurable objectives are seen when you compare the assessment data on the initial visit with the post-partum termination visit data. Birth outcomes are also measured. One of the major accomplishments has been an increase in client awareness of the dangers of substance use during pregnancy. Although many clients do not stop smoking completely, there are a considerable amount that cut down their use.

Program Evaluated?

Yes.

Would It Work Elsewhere?

I think that PSUPP would work in other urban communities because most prenatal clinics do not fully address substance abuse issues. Having a specific person to access substance use only can be a great help to clinic social workers.

Replicated Elsewhere?

NA

Indianapolis, Indiana

Beds and Britches, Etc.

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Initiative Categories

Women's Health	Perinatal Health
• Preconception health promotion	• Prenatal care

Initiative Description

"Recognizing the need to constantly devise new methods to combat infant mortality, BABE was introduced in Marion County to encourage clients to seek timely medical care and to promote healthy living."

Beds and Britches, Etc. (BABE) is a community-based incentive program designed to improve the health status of a targeted population: pregnant women, infants and children. Recognizing the need to constantly devise new methods to combat infant mortality, BABE was introduced in Marion County to encourage clients to seek timely medical care and promote healthy living.

Families can receive coupons by keeping prenatal appointments, well child appointments, getting immunizations, attending health nutrition classes, breast-feeding classes and other health related services. The coupons are then traded at the BABE store for new or gently used merchandise such as maternity clothes, infant and toddler clothing, car seats, cribs, etc. Clients feel they have earned the coupons by their participation in the health care system, and we have found increased attendance in our programs.

Three stores are scheduled to open in 1995, each of the major hospitals in Indianapolis agreed to sponsor one of these stores. In addition, we have the support of the neighborhood health centers, county care coordination teams, public health nursing, community groups and organizations, local department stores, and individual volunteers.

In the spirit of "It takes a village to raise a child," this project has brought the community together in an effort to reduce the infant mortality rate in Indianapolis.

Funding Sources

- City/county government funds
- Private sources
- Public & private partnerships

Budget
$100,000

Partnerships

"We adapted the program for this community, gained the support of the mayor's office..."

The Marion County Health Department has provided the leadership necessary to develop this project. We adapted the program for this community, gained the support of the mayor's office, coordinated the efforts of the local health care providers as store sponsors and coupon distributors, and established relationships with community organizations.

Leadership Enhanced?

The success of this program has enhanced the reputation of the Marion County Health Department as a forerunner in bringing new and creative strategies to the community to reduce infant mortality.

Barriers & Strategies

Barrier 1: Maintaining control of inventory so that each store will offer the same quality of merchandise.

Barrier 1: A central distribution center was established. All merchandise donated to the distribution center is then delivered to the stores.

Objectives / Data / Accomplishments

Our goal is to reduce infant mortality by improving attendance in maternal and child health services offered throughout the county. Each coupon contains demographic information about the clients and identifies the program that clients attended to receive the coupon. Therefore, we will have data to evaluate client participation and attendance in maternal and child health services. The major accomplishment to date is the amount of cooperation and support the program has received from the community.

Program Evaluated?

Yes.

Would It Work Elsewhere?

This approach can work well in any community where there is under utilization of existing maternal and child health services.

Replicated Elsewhere?

Yes. Rockford, Illinois; South Bend, Indiana; Mishawaka, Indiana; Evansville, Indiana.

Lexington, Kentucky

Maternity Program

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Initiative Categories

Women's Health	Perinatal Health
• Preconception health promotion • Family planning	• Expanding maternity services

Initiative Description

"...including family planning, preconceptional health counseling, preconceptional health screening, and blood pressure assessment by Maternity Program nurses."

The Maternity Program implemented the provision of individualized prenatal, postpartum including family planning, preconceptional health counseling, preconceptional health screening, and blood pressure assessment by Maternity Program nurses for patients receiving WIC services at the WIC site in Pimilico Public Housing in June 1995.

The patient is advised to schedule an appointment and/or is assisted with scheduling an appointment with her obstetrician for any medical problems that are identified. The majority of these clients are already enrolled for prenatal care at the University of Kentucky Medical Center. Some are enrolled with private obstetricians and others are also enrolled as Lexington-Fayette County Health Department Maternity Program patients.

The service is presently offered three half days per week.

It is projected that 115 clinics or 1,150 nurse visits per year would be provided.

Funding Sources

- City/county government funds
- General state funds
- MCH Block Grant funds
- Medicaid insurance

Budget
$640,410

Partnerships

See text...

The planning and implementation of activities were cooperative efforts between the University of Kentucky OB/GYN Clinic, private obstetricians, Lexington-Fayette Health Department Maternity program staff and the Lexington-Fayette County WIC program staff.

Leadership Enhanced?

Communication among staff of all agencies and the coordination of patient care of patients seen jointly by these agencies has been enhanced.

Barriers & Strategies

Barrier 1: Space for staff to provide services.

Strategy 1: Services are provided in a small one bedroom apartment in a low-income housing project. Staff share space in the small bedroom.

Objectives / Data / Accomplishments

Yes, the initiative has measurable objectives which will be used to monitor the program. It is too new to evaluate major accomplishments. It is projected that 115 clinics or 1,150 nurse visits per year will be provided.

Program Evaluated?

No.

Would It Work Elsewhere?

Yes. This initiative could be successful in any area if there is communication and collaboration between those agencies and providers who provide the service.

Replicated Elsewhere?

No.

Louisville, Kentucky

Project Link

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Initiative Categories

Access to Care
- Case management

Strengthening Public Health
- Staff training
- Building coalitions

Perinatal Health
- Prenatal care
- Substance abuse

Initiative Description

"...is an outreach, case management, and health evaluation program designed to identify, assess, and link pregnant and post partum women to chemical dependency treatment and other resources in the community."

Project Link is a joint venture between the Jefferson Alcohol and Drug Abuse Center (JADAC) and the Jefferson County Health Department. JADAC is a unit of Seven Counties Services, the local community mental health agency. The project is an outreach, case management, and health evaluation program designed to identify, assess, and link pregnant and postpartum women to chemical dependency treatment and other resources in the community.

A local needs assessment had determined that health care providers were not identifying alcohol/drug abuse in women and that women were not receiving alcohol/drug treatment they needed.

The goals of Project Link include increasing the number of pregnant and postpartum women identified and referred to treatment, expanding alcohol/drug treatment services for 120 pregnant women each year, providing data about effectiveness, expanding coordination between prenatal/postpartum service agencies and alcohol/drug treatment agencies, and improving health outcomes and the quality of life for project participants and their infants. Services are offered at seven prenatal care clinics operated by the Jefferson County Health Department and the University of Louisville Hospital clinic in the downtown medical center.

Funding Sources

- Other federal funds, Center for Substance Abuse Treatment, Kentucky Department for Mental Health and Retardation.

Budget
$220,000

In addition, referrals are received from the University of Louisville Hospital obstetric services and emergency room, two school based programs for pregnant and parenting teens, and local community health centers. To receive case management services for one year, women must receive prenatal care at health department or university centers. All prenatal patients are assessed for alcohol and other drug use at time of enrollment through the use of a simple client completed screening questionnaires and interviews with a case manager. Staff includes a project director, part-time administrative assistant, four case managers and a health educator. An advisory council composed of project partners and representatives of agencies that provide services to pregnant/postpartum and alcohol/drug dependent women meets every other month. Case management services began during May, 1993.

Partnerships

"...collaboration between health and substance abuse providers made possible the development and implementation of an initiative that addresses the medical and chemical dependency needs..."

The original project proposal and request for funds was prepared by staff of the Jefferson Alcohol and Drug Abuse Center and the Jefferson County Health Department with the involvement of a nurse researcher from a local university who wrote the evaluation component. This collaboration between health and substance abuse providers made possible the development and implementation of an initiative that addresses the medical and chemical dependency needs of project clients.

Louisville, Kentucky — Project Link

Leadership Enhanced?

Project Link has enhanced working relationships between the health department and community substance abuse and social service agencies. This is one of several community collaborations in which the health department is an active participant. Simultaneously the health department is implementing APEX and developing a community health plan to address eighteen CDC consensus indicators. The leadership role of the department is, as a result of all of these initiatives, being more widely recognized.

Barriers & Strategies

Barrier 1: Pregnant women with drug and alcohol problems were not always being identified by health care providers.

Strategy 1: Even with extensive histories and detailed assessment processes, only 3.5 percent of health department prenatal patients were determined to have alcohol/drug problems before Project Link. An initial activity was to provide basic training on chemical dependency to health care personnel to enhance their assessment skills. Time was spent educating health care providers on the role of the case managers who could perform a thorough screening of substance use. A screening questionnaire has been implemented.

Barrier 2: There were not enough residential treatment beds in community facilities that would accept pregnant women and/or women with children.

Strategy 2: Project Link has helped raise community awareness about the needs of chemically dependent women in general and more specifically about the demand for additional residential services that would admit pregnant women and women with children. As a result funds have been secured for several additional facilities. Bed capacity is still not adequate but it is greatly improved, and communications among project and facilities personnel are enhanced.

Objectives / Data / Accomplishments

The evaluation plan consists of process and program evaluation, and the full evaluation report will include program effectiveness, formative evaluation, and outcome evaluation. Case managers enter data on laptop computers which is then down loaded onto a personal computer. From this data base monthly, quarterly and annual reports are prepared. Project patients deliver in one hospital, and appropriate agreements have been negotiated so that hospital records can be accessed.

Since process data is available in a timely manner, program activities are consistently monitored. Necessary changes can often be determined and implemented very quickly.

The nurse evaluator is currently reviewing hospital records to determine the project's impact on maternal and infant outcomes. Funds may not be available for this level of evaluation beyond the first project year.

Program Evaluated?

No. In progress.

Would It Work Elsewhere?

Similar arrangements should be effective in communities where health and substance abuse staff collaborate effectively. A major advantage of Project Link is that the case managers see patients in the clinics and are identified as members of the health care team.

Replicated Elsewhere?

No. The Kentucky Department for Mental Health and Mental Retardation Services is interested in replicating the project if funds are available.

Portland, Maine

Portland International Health Program

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Initiative Categories

Strengthening Public Health	Access to Care
• Building coalitions	• Overcoming cultural barriers • Case management

Initiative Description

"As a result, a core group of representatives from nine different agencies started meeting every other week to conduct a case conference on a family with unmet health or social service needs."

The mission of the Portland International Health Program is: "To coordinate services of several agencies to maximize immigrants' access to health care and other services including housing, nutrition, education, social services and needed welfare benefits." There was a growing recognition among service providers in that Portland was becoming increasingly ethnically diverse. A group of these providers gathered to discuss how to better collaborate and coordinate services provided to non-English speaking peoples in the community.

As a result, a core group of representatives from nine different agencies started meeting every other week to conduct a case conference on a family with unmet health or social service needs. Family members are invited to attend the conference. Consent to share information with the core team is obtained prior to the meeting. In this way the benefits of provider networking, sharing resources and avoiding duplication of efforts has vastly improved the system maze for families and facilitated ongoing communication among providers.

Funding Sources

• Other: Cost of interpreter at case conference is covered by "presenting" agency.

Budget
NA

Partnerships

See text...

Members of the Public Health Division were instrumental in both the planning and implementation of this program. All nine members of the core team feel committed and invested in this effort as a way to better meet the needs of minority groups in Portland.

Portland, Maine — Portland International Health Program

Leadership Enhanced?

Yes. The health department took a leadership role in seeing a need for a proactive approach to the issue of growing ethnic diversity and limited resources to combat problems of racial bias and discrimination.

Barriers & Strategies

Barrier 1: Obtaining consent to share information among members of the core team.

Strategy 1: A consent form was drafted. Lawyers consulted to ensure legality of consent. The member of the team who was "presenting" a case was responsible for obtaining a signed informed consent from the family.

Barrier 2: Lack of interpreters in the community. No interpreters formally trained.

Strategy 2: Currently all members of the team are responsible for securing an interpreter, as needed, when providing direct services to a family. The team is exploring the possibility of approaching an agency interested in training and offering interpreter services.

Objectives / Data / Accomplishments

The main objective of this program is to enhance communication and coordination of services to minority groups. This has been successfully accomplished through the commitment of the core team who have put time and energy into meeting regularly.

Program Evaluated?

NA

Would It Work Elsewhere?

Yes. Additional funding sources are not required. The program enhances communication among community providers and better serves the needs of families when services are coordinated.

Replicated Elsewhere?

Don't know.

Baltimore, Maryland

Adolescent Life Skills Building Initiative

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Initiative Categories

Women's Health	Perinatal Health
• Preconception health promotion	• Breast feeding/ nutrition/WIC

Initiative Description

"Leadership development, conflict resolution, goal setting and healthful living are some of the program components. This is done through interactive group approaches in the outreach center and other areas."

The overall goal of the initiative is to offer comprehensive life planning skills for young people and enhance their ability to become responsible and productive adults.

Leadership development, conflict resolution, goal setting and healthful living are some of the program's components. This is done through interactive group approaches in the outreach center and other areas.

The Baltimore City Health Department has a team of health educators, peer counselors, and outreach coordinators who provide information and education on health and social issues to young men and women. Subjects include employment, family planning, substance abuse, parenting, education and housing. This information and education is provided within various health sites, schools, community sites and an outreach/ education center in Baltimore City.

Funding Sources

• General state funds

Budget
$192,035

Partnerships

See text...

The Baltimore City Health Department has been the principal agent of this initiative by coordinating activities and providing staff training and development.

Leadership Enhanced?

Yes. This initiative has allowed other organizations and agencies to network with the health department and increase the leadership role of the health department.

Barriers & Strategies

Barrier 1: Lack of funding.
Strategy 1: Obtain grants to supplement the initiative.

Barrier 2: Lack of space.
Strategy 2: A new outreach and education center will open to provide additional activities.

Objectives / Data / Accomplishments

Yes, data is collected through monthly staff reports and health education and outreach summaries. Major accomplishments to date include:

- peer counseling component
- ongoing male and female groups and clubs
- entrepreneurship program
- community service projects
- ongoing health education and counseling

Program Evaluated?

No.

Would It Work Elsewhere?

Yes. This initiative would be easy to replicate, yet it depends on long-term success in order to produce a significant impact. The success of the initiative largely depends on a team of individuals who enjoy working with teens and young adults.

Replicated Elsewhere?

No.

Boston, Massachusetts

Infant Mortality Review (IMR)

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Initiative Categories

Perinatal Health
- Low birthweight/ infant mortality

Access to Care
- Case management & care coordination

Strengthening Public Health
- Strategic planning
- Managed care initiatives
- MCH data capacity
- Infant/child death review

Initiative Description

"The project is a citywide collaboration of health and social services providers, researchers, advocates, community residents and policy makers."

The overall purpose of the Infant Mortality Review (IMR) is to understand the clinical, social and health care context in which infant deaths occur in Boston, and to apply this understanding to the development of policies and programs to improve the health of women and infants at high risk of infant death and its major precursors, low birth weight and prematurity.

The project is a citywide collaboration of health and social services providers, researchers, advocates, community residents and policymakers. It seeks to engage these collaborators in reviewing cases, educating one another and taking action together. During the first phase of the project, all infant deaths to residents of Boston between 1/1/90 and 6/30/91 (144) were studied. The second phase was a review of infant deaths to residents of Boston's highest risk neighborhoods from 1992 to 1994 (176). The project's methods were:

- collection of data from the medical records for all cases
- personal interviews with as many mothers as possible following the death of their infant
- for cases which both sources of information are unavailable, the presentation of a clinic/social case summary to an interdisciplinary panel of reviewers
- policy development and implementation with the collaboration of city-wide representatives from hospitals, health centers, insurers, legislators, policymakers, and the affected communities

Funding Sources

- Other federal funds
- Healthy Start initiative (MCHB)

Budget
$125,000

The panel reviews focus on the public health and clinical policy lessons that can be drawn from each case. Each case is discussed by the reviewers in detail, with the risks and the service responses to these risks noted. A set of policy implications and recommendations are then generated based on each case. These have both clinical and public health implications for the delivery of service within managed care systems. Based on these recommendations, city-wide partners are engaged in developing joint policy initiatives related to managed care reimbursement and the prevention of prematurity.

Partnerships

"The entire process is based on partnerships with health centers..."

The health department provided the impetus and leadership for convening all review panels and policy development groups. The entire process is based on partnerships with health centers, hospitals, community-based agencies and state-sponsored health and human service programs.

Boston, Massachusetts

Infant Mortality Review (IMR)

Leadership Enhanced?

Yes. The health department is seen as a leader in maternal health policy development.

Barriers & Strategies

Barrier 1: Sustaining regular participation of a wide range of panel members, especially obstetricians.

Strategy 1: 1) Changed commitment to bimonthly, 2) Changed panel composition after 18 months.

Barrier 2: Sustaining role of senior health department managers for policy development implementation amidst political changes and competing demands.

Strategy 2: 1) Time and persistence. 2) Engagement of senior level managers outside of the health department.

Objectives / Data / Accomplishments

Objectives:

- to describe context in which infant deaths occur.
- to identify system failure in delivery of women's and infants services.
- to engage providers, educators, consumers, and administrators of diverse backgrounds and expertise in a process of community change.

Accomplishments:

- useful descriptive data base on infant mortality (now augmented by control group data)
- two major policy initiatives in development: 1) managed care reimbursement reform and 2) clinical policies related to prevention of prematurity.

Program Evaluated?

No.

Would It Work Elsewhere?

Yes. The model can be adapted to meet local needs and resources, and it leads local policy making in a way that is concrete and visible.

Replicated Elsewhere?

Yes. Healthy Start & American College OB/GYN funded sites.

Detroit, Michigan

Preventing Adolescent Substance Abuse

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Initiative Categories

Perinatal Health
- Prenatal care

Child Health
- Expanding child health services

Adolescent Health
- Teen parenting

Access to Care
- Case management

Strengthening Public Health
- Building coalitions

Initiative Description

"Among the primary objectives of the PASA program is the elimination of substance abuse among youth."

The Detroit Health Department has taken a leading role in identifying the need for adolescent child health promotion programs in urban areas. As a lead public health agency, the Detroit Health Department has successfully developed and implemented the Preventing Adolescent Substance Abuse (PASA) program as well as other projects which encourage healthy living.

The PASA program provides health promotion, maternity/obstetrical-related services, comprehensive case management and substance abuse treatment services, parenting information and peer education to adolescents between the ages of 12-18 years of age.

The program is not just for pregnant and parenting adolescents. PASA is unique in that it also targets adolescents who are at risk for substance abuse. Among the primary objectives of the PASA program is the elimination of substance abuse among youth.

Specific PASA services include home visits, infant assessments, health education, drug prevention services, parenting education, client incentives and related activities, individual, group and family therapy, transportation and child care.

Funding Sources

- Other federal funds

Budget
$457,000

Partnerships

See text...

The Detroit Health Department has established several significant community partnerships in the Detroit areas. This has met with the provision of health promotion services in low and moderate income areas.

Leadership Enhanced?

Yes. Through resources and qualified staff, PASA is continuing as an effective program for adolescents, male partners, and most importantly, infants and children.

Barriers & Strategies

Barrier 1: Lack of consistent adolescent participation.

Strategy 1: A variety of methods have been used to recruit and retain pregnant and parenting adolescents. Client incentives (baby items, personal hygiene products and cultural activities) seem to be encouraging consistent involvement in program activities. It is anticipated that additional incentives and special activities can be provided in future programming.

Barrier 2: Collaboration with community organizations.

Strategy 2: In working with community-based organizations, the PASA program has met with some reluctance among various community organizations that do not realize the potential for collaborative health promotion efforts. This resistance has resulted in many clients not receiving the full benefit of program services. This challenge has been overcome by involving a variety of organizations in planning of activities.

Objectives / Data / Accomplishments

The PASA program has specific measurable objectives. Data is collected from three groups (Groups A, B, C) through pretest and posttests. Data on depression and self esteem, parenting, alcohol and other drug prevention and decision making is collected by trained evaluation researchers.

Preliminary findings indicate that the PASA program is targeting an appropriate population of girls. Moreover, the data on depression and self esteem indicate that the girls are depressed.

Program Evaluated?

Yes.

Would It Work Elsewhere?

Yes.

Replicated Elsewhere?

No.

Flint, Michigan

Church Health Team Project

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Initiative Categories

Access to Care	Access to Care
• Increasing social support	• Overcoming cultural barriers
• Increasing access to Medicaid	• Clergy & health connections
• Other outreach activities	• Schools & health connections

Initiative Description

"The goal of the church health teams is to infiltrate the church membership with health information and link the church members with needed health services."

The Church Health Team Project began two years ago as a part of a larger Community Based Public Health project funded by the Kellogg Foundation. Five churches participate in the project with three to four members on each team. The goal of the church health teams is to infiltrate the church membership with health information and link the church members with needed health services.

The five teams work independently at their respective churches, but conduct a variety of health activities as a collaborative group. The health department provides technical support to the project, but all education and referral is conducted by the trained church health team members through the home visits, phone calls, or planned group activities at the church. Heart health has been the focus of the teams over the past year.

Activities have included smoking cessation programs, healthy cooking classes, one-on-one education and referral.

Funding Sources

- The Kellogg Foundation

Budget
$15,000

Partnerships

"In addition, we have been readily available for moral support."

The health department has provided technical support in the form of grant writing, liaison activities, development and implementation of the training, supplying educational materials, and linkage to other health department services. In addition, we have been readily available for moral support.

Leadership Enhanced?

Yes. The health department has been seen as a valid partner with the community. No longer are we seen just as a governmental agency, we are a key player in helping to improve the community's health.

Barriers & Strategies

Barrier 1: Limited knowledge of how community organizations run.

Strategy 1: The health department and the churches have met on a regular basis over the past two years to understand each others "systems," In addition, the health department has provided technical support in the area of accounting.

Barrier 2: Lack of funding.

Strategy 2: The churches and the health department are actively seeking funding from a variety of sources including the state health department.

Objectives / Data / Accomplishments

This project is evaluated as a part of a larger community-based public health project. The goals are:

- to promote the publics health by enhancing the capacity of community members and community based organizations.
- to modify existing systems and to create alternative systems with the community to promote public health.
- to provide resources to community members to enhance their capacity to address public health concerns.

Our first goal has been met as 23 church health team members are involved. Our second goal is being met as the churches have been providing input into the development of new and existing projects. In our final goal, the church team members have been trained by the health department. They have provided numerous health education programs in the community.

Program Evaluated?

Yes.

Would It Work Elsewhere?

Yes. If the health department is willing to work real hard to understand community residents and really listen to what community residents have to say, this project could work anywhere.

Replicated Elsewhere?

No.

Grand Rapids, Michigan

Health Kent 2000: Community Health

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Initiative Categories

Strengthening Public Health
- Strategic planning for urban MCH
- Building coalitions

Initiative Description

"In addition to client education, PSUPP is involved with educating the community on the dangers of substance use during pregnancy."

Healthy Kent 2000 is a project designed to involve the community in the development of a community health plan for Kent County. The Healthy Kent 2000 Committee evolved from the Steering Committee for the Kent County Initiative to Reduce Infant Mortality. This evolution was a natural progression as it became clear that in order to impact maternal and infant health outcomes in the long-term, emphasis needed to be placed on family-based, culturally appropriate health and health care services across the entire life span.

The Healthy Kent 2000 Committee completed a comprehensive community health assessment which included qualitative and quantitative information concerning health status, health risks, and health perceptions. After completion of the health assessment, six priority community health problems were identified: Infant Morbidity and Mortality; Substance Abuse; Chronic Disease; Community Violence; Child Abuse and Neglect/Domestic Violence; and Sexually Transmitted Diseases/AIDS.

Subcommittees have formed around each of the priority problems in order to establish community-wide goals, measurable objectives and strategies to impact each health problem.

Funding Sources

- City/county government funds
- Steelcase Foundation
- Chamber of Commerce
- Local hospitals

Budget
NA

Partnerships

See text...

The health department is one of more than 30 community players collaborating to improve the health of the Kent County community. The health department has provided leadership and staff support for the initiative.

Leadership Enhanced?

Yes. This initiative has allowed the health department to continue in its leadership role in this community. The health department is recognized as a neutral player which can convene diverse groups and interests in order to assure that the health needs of the community are met.

Barriers & Strategies

Barrier 1: Community ownership of the process.

Strategy 1: In order for this initiative to be successful, the community needs to be more than participants in the process and take on its ownership. The initiative is sometimes seen as only a health department project. In order to overcome this, the health department has and will continue to encourage community investment, involvement and ownership of the project.

Barrier 2: Short-term vs long-term success.

Strategy 2: For this initiative to be successful, changes need to occur in the way individuals and agencies view their health and their community's health. These value and attitude changes could take many years. However, there is a need to demonstrate to the community the successes and the impact of the initiative in the short term. Therefore, the committee is working towards the establishment of both long and short-term goals and objectives.

Objectives / Data / Accomplishments

The initiative is developing measurable objectives to gauge progress toward obtaining community goals for each of the six priority areas. Baseline data are being collected from a variety of local and state sources.

The initiative has accomplished many activities to reach the point of establishing community objectives, including completion of a behavior risk factor survey, conducting 16 focus groups in six different "special populations," analysis of health status data, and prioritization of the community health problems.

Program Evaluated?

Yes.

Would It Work Elsewhere?

I think that PSUPP would work in other urban communities because most prenatal clinics do not fully address substance abuse issues. Having a specific person to access substance use only can be a great help to clinic social workers.

Replicated Elsewhere?

NA

Minneapolis, Minnesota

Project LID (Lower Infant Deaths)

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Initiative Categories

Perinatal Health
- Low birthweight/ infant mortality

Strengthening Public Health
- Infant/child death review activities

Initiative Description

"Saint Paul Public Health examined 66 Twin Cities' infant deaths in 1993 using a case-by-case review format incorporating information obtained from medical records, birth certificates and home interviews."

This interagency pilot project of the Minneapolis Department of Health and Family Support and Saint Paul Public Health examined 66 Twin Cities' infant deaths in 1993 using a case-by-case review format incorporating information obtained from medical records, birth certificates and home interviews. The deaths were categorized by the review team as: preventable (15 percent), possibly preventable (32 percent), not preventable (35 percent), and could not evaluate (18 percent) based on data from the above sources. The multi-disciplinary, interagency case review teams identified gaps in service due to parental issues, professional care and service linkage problems which contributed to the preventable and possibly preventable infant deaths. Recommendations regarding these concerns were passed on to a community advisory group for recommendations on policy development and needs for education, and programs research to address and facilitate long-term solutions to the unmet needs of parents and medical social services systems issues.

Funding Sources

- General state funds

Budget
NA

Partnerships

See text...

In addition to the partnership of the two city health departments, both the case review teams and the community advisory group were comprised of a broad spectrum of representatives from health and human service agencies and HMO's.

Minneapolis, Minnesota

Project LID (Lower Infant Deaths)

Leadership Enhanced?

Yes. The health department has been identified as a lead agency in the state in looking at infant mortality. The project provides an excellent example of the role of a public health agency in assessment and policy development, and the bringing together of a broad collaborative to work towards a common goal.

Barriers & Strategies

Barrier 1: Access of information and tracking records.

Strategy 1: Repeated phone calls and meetings with representatives from hospitals and vital records.

Objectives / Data / Accomplishments

The objectives were to identify the factors contributing to the unacceptably high infant mortality rates in the Twin Cities, and to use that information for program and policy development in Minneapolis, St. Paul, and greater Minnesota. An additional objective was to develop a process that could be replicated in other communities.

Data was collected through birth/death records, medical records and home interviews, and was then summarized for the case review team to evaluate factors of the deaths and to determine the level of preventability.

The major accomplishment has been the development of conclusions for program and policy development.

Program Evaluated?

Yes.

Would It Work Elsewhere?

Yes. The final report includes all aspects of the project to allow for replication. The project is being used as a model for development of projects statewide to be funded through the Minnesota Department of Health.

Replicated Elsewhere?

No.

St. Paul, Minnesota

Newborn Immunization Tracking

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Initiative Categories

Child Health
- Immunization

Strengthening Public Health
- Immunization tracking & recall

Access to Care
- Expanding private sector linkages
- Other outreach activities

Initiative Description

"The participating St. Paul hospitals agreed to educate new parents living in the five high-risk zip codes about immunizations, and gain permission to have their infants followed in the IAP Newborn Tracking system."

The Newborn Tracking Program is funded through Immunization Action Plan (IAP) grants distributed by the Centers for Disease Control and Prevention and the Minnesota Department of Health (MDH). St. Paul IAP staff used retrospective kindergarten immunization data published by MDH to identify ZIP codes in the city where children were at risk for being under immunized. These areas were targeted in a partnership developed between the IAP and five local hospitals where the majority of St. Paul infants are born. The participating St. Paul hospitals agreed to educate new parents living in the five high-risk ZIP codes about immunizations, and gain permission to have their infants followed in the IAP Newborn Tracking system. To reinforce the link between participating parents and the primary care clinic of their choice, the first well child check was scheduled before the family left the hospital.

During 1994, the first year of the program, a total of 1,216 babies were enrolled. Basic demographic information was entered into the computer tracking system. Their receipt of immunizations was monitored through requests for information from the clinic that the parent identified at the time of enrollment. If the child fell behind on immunizations, a phone call was placed to remind the parents that their child was overdue for immunizations. If no current phone number was identified, a letter was sent or, as a last resort, a home visit was made.

Funding Sources

- CDC funding through state
- Other federal funds

Budget
$150,000 first year
$120,000 second year

Partnerships

See text...

St. Paul Public Health has been the primary coordinator for this project and has worked as a partner with the hospital staff providing assistance, information resources and encouragement.

St. Paul, Minnesota

Newborn Immunization Tracking

Leadership Enhanced?

St. Paul Public Health has developed enhanced leadership skills of staff through this project, and also has been recognized as a leader in childhood immunization outreach activities.

Barriers & Strategies

Barrier 1: Convincing hospital administration and staff to participate in the program.

Strategy 1: For the first year of operation, the hospitals were reimbursed a flat fee for each tracking form which was completed. Upon entering the second year, hospitals have agreed to continue the activity without the reimbursement.

Objectives / Data / Accomplishments

A computerized tracking system is utilized to monitor activity and immunization status. A substantial improvement in the percent of babies beginning their primary series is evident in each of the five high-risk ZIP codes. Walter Orenstein, director of the National Immunization Program, has determined that children not immunized before three months are most at risk for not being up-to-date at 12 or 24 months. Therefore, it is significant that in all ZIP codes, the number of babies receiving their first DTP in a timely manner increased by at least 10 percentage points. Overall, 77 percent of the participants received their first DPT by three months, compared to 60 percent of those surveyed in the Retrospective Kindergarten Study. An analysis of babies born in the first half of 1994 indicated a higher percentage of the children enrolled in Newborn Tracking received their first DPT by three months, their second by five months, their third by seven months, compared to the Retrospective Kindergarten study results.

Program Evaluated?

Semiformally by our department, with additional interest from the MDH.

Would It Work Elsewhere?

Yes. This would work in another urban community provided that all partners are willing and resources can be allocated.

Replicated Elsewhere?

Unknown.

Kansas City, Missouri

Mid America Immunization Coalition

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Initiative Categories

Child Health
- Immunization

Initiative Description

"A coalition of area service providers was formed... to address relatively low immunization rates."

Immunization rates for Kansas City's two-year-old population remain relatively low. A coalition of area service providers was formed, under the leadership of Children's Mercy Hospital, with initial support from the Junior League of Kansas City, to address the problem.

The health department saw this as an opportunity to present all of the service providers with a variety of intervention strategies, and played a supportive and collaborative role, rather than a controlling one.

Among the accomplishments to date: an electronic immunization record that will link public and private providers, immunization "days" and "weeks" with special clinics, professional seminars, videos for waiting rooms and a great deal of public awareness and education.

Funding Sources

- Charitable foundation
- Children's Mercy Hospital

Budget
NA

Partnerships

See text...

As an active participant, one of many partners.

Kansas City, Missouri — Mid America Immunization Coalition

Leadership Enhanced?

The coalition was initially founded and funded by the Children's Mercy Hospital. The department had some goals it was able to accomplish by working with the coalition, not trying to control it. The demonstrated collaborative role enhanced the leadership role of all of the participants.

Barriers & Strategies

Barrier 1: Standardizing immunization delivery systems throughout the metropolitan area.

Strategy 1: Both public and private providers operated under a number of service delivery protocols. Series of forums and meetings with providers led to consistency throughout the metro area. A formal seminar and a video, produced by the coalition, addressed provider "missed opportunities."

Barrier 2: Encourage funders to pursue long-term strategies rather than one-time, high profile events.

Strategy 2: Educate funders on the nature of the problem using patient exit interview dates, both locally and nationally. Illuminate why patients don't strive to have their children immunized, allowing interventions modeled on actual behaviors.

Objectives / Data / Accomplishments

To raise the immunization levels of infants and children through coordinating direct services, enhancing record retrieval and public awareness. Data from participating agencies are reviewed.

Program Evaluated?

No.

Would It Work Elsewhere?

NA

Replicated Elsewhere?

Yes.

St. Louis, Missouri

Medicaid Managed Care Enrollment

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Initiative Categories

Access to Care
- Increasing access to Medicaid

Initiative Description

"The goals of MC+ are to improve Medicaid recipients' access to health care and reduce the costs of providing that care."

This initiative involves the St. Louis Department of Health and Hospital's role in promoting and assisting with the enrollment of Medicaid recipients into Missouri's Medicaid Managed Care program (MC+). The goals of MC+ are to improve Medicaid recipients' access to health care and reduce the costs of providing that care.

In January, 1995, the Missouri Department of Social Services selected seven HMOs to provide health care for pregnant women, AFDC recipients, refugees, and children in state custody who live in a five-county area. In St. Louis, the enrollment process was begun in July, 1995 by the state-selected Health Benefits Manager (HBM). The HBM and many of the seven selected HMOs have little experience in working the Medicaid population. Consequently, some of their efforts in providing information about their plan and about MC+ were ineffective.

Early on, the department worked with a task force of local and state representatives to determine strategies for informing the eligible Medicaid recipients of the coming change in their health care. The task force developed a marketing plan that included the production of print and video materials that were distributed to Medicaid recipients.

One major goal was that of getting information to approximately 90,000 St. Louis MC+ recipients to enroll in the program. The state will "auto-assign" Medicaid recipients who do not enroll by September 15, 1995. The department developed several outreach strategies to inform and encourage the MC+ eligible persons of the need to enroll in the program.

Funding Sources

- City/county government funds
- Other federal funds

Budget
NA

Partnerships

"We worked closely with the Missouri departments of Health and Social Services, the Health Benefits manager and with other agencies involved in the process of encouraging MC+ recipients to enroll."

St. Louis Department of Health and Hospitals managers and staff helped develop strategies for informing the public and Medicaid recipients of MC+. We worked closely with the Missouri departments of Health and Social Services, the Health Benefits manager and with other agencies involved in the process of encouraging MC+ recipients to enroll.

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Leadership Enhanced?

Yes. The leadership of the St. Louis Department of Health and Hospitals was enhanced as a result of our participation in this activity. This was the first time that staffs of the local health departments for the five geographical areas collaborated in a single project. Our participation showed that the St. Louis Department of Health and Hospitals could and would play an important part in working with other departments to programs that affected a wide portion of the St. Louis area.

Barriers & Strategies

Barrier 1: The Health Benefits Manager's (HBM) lack of knowledge of the population and the best methods of reaching eligible MC+ recipients.

Strategy 1: The department worked closely with HBM and advised on the best approaches for reaching eligible recipients. The department committed about 30 of its MCH for staff risk reduction outreach workers to MC+. These outreach workers canvassed neighborhoods, met one-on-one with residents, and promoted MC+ by distributing fliers, brochures and other materials. The department also conducted training on MC+ for more than 70 additional staff who have client contact.

Barrier 2: Lack of state funding for outreach to promote MC+.

Strategy 2: The state budgeted few funds for promotion of MC+. The two or three agencies have submitted proposals to coordinate outreach activities. However, the state seems to feel that outreach is the responsibility of the HBM. Several organizations involved in outreach and promotion of MC+ have communicated on a somewhat limited basis to begin developing a strategy for coordination of outreach and promotion of the program.

Objectives / Data / Accomplishments

The state's goal is to have 90 percent of eligible Medicaid recipients select an HMO and a primary care physician by September 15, 1995. Persons who do not select a plan will be "auto-assigned." The HBM estimates that by the end of July, only about 13,000 Medicaid recipients had actually signed up.

This department has requested weekly enrollment updates by enrollment location from the HBM to aid in evaluating which outreach strategies are most effective. The HBM personnel have said that information is not available. However, they said that we could get updates on the total number of people who have signed up for MC+.

The Missouri Department of Social Services plans to implement MC+ in other parts of the state early next year. The lessons learned from the St. Louis area implementation will be valuable in helping to refine strategies for promotion of the program that should result in more recipients being enrolled more quickly.

Program Evaluated?

No.

Would It Work Elsewhere?

The Missouri Department of Social Services plans to implement MC+ in other parts of the state early next year. The lessons learned from the St. Louis area implementation will be valuable in helping to refine strategies for promotion of the program that should result in more recipients being enrolled more quickly.

Replicated Elsewhere?

No.

Missoula, Montana

Partnership for Strengthening Families

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Initiative Categories

Perinatal Health
- Home visits

Child Health
- Early intervention

Access to Care
- Case management

Strengthening Public Health
- Building coalitions & partnerships

Initiative Description

"...programs planned at the community level which would prevent child abuse and neglect, strengthen vulnerable families and reduce the need for out of home area."

Partnership For Strengthening Families was developed by a coalition of parents and 21 community agencies and organizations. The local project was undertaken in response to an opportunity offered by the Montana Department of Family Services encouraging and providing funding for programs planned at the community level which would prevent child abuse and neglect, strengthen vulnerable families and reduce the need for out of home care.

The community needs/resource assessment and project planning process occurred over a nine month period, guided by a steering committee with input from several task groups. The resulting community program is an interagency partnership between the health department, parenting education agency, child care resource agency, teen pregnancy services and the library. The Partnership to Strengthening Families is directed by a managing council comprised of four parents and three agency representatives (not receiving project funding.)

The comprehensive program is based upon principles developed by the coalition and provides services which were identified by the group as essential to meeting family needs and outcome goals of the program. Public health nurses and social workers provide intensive home visiting and case management in partnership with high risk families. Enrollment in the "Nurturing Program" is encouraged including a special teen group; respite and crisis nursery care is readily accessible; parenting resources and literacy support are provided through the library.

Funding Sources

- City/county government funds
- General state funds

Budget
$200,000

Partnerships

"Working in partnership with other agencies and providing leadership in community coalition development has been a longstanding tradition of this health department."

Building this composite of child and family services has demonstrated to the community the advantages of collaboration. Working in partnership with other agencies and providing leadership in community coalition development has been a longstanding tradition of this health department. Examples include: the Nutrition Resource Council, Access Links Prenatal Program and Partnership Health Center which provides access to volunteer physicians and are supported by hospitals and the Network for Adolescent Pregnancy Services.

Leadership Enhanced?

The health department played a significant role throughout the inter-agency planning process facilitating communication, assessing family needs on behalf of the coalition and sharing resource information this agency has compiled. The "extra effort" and leadership provided by this agency was recognized and appreciated by other coalition members.

Barriers & Strategies

Barrier 1: Trust and competitiveness among agencies.

Strategy 1: Each task group included parent members reminding agencies of project goals and family needs.

Barrier 2: Limited funding.

Strategy 2: Building on and enhancing existing resources and setting priorities. Our Neighborhood Nurse Program provided a foundation for intensive home visiting component.

Objectives / Data / Accomplishments

A standing evaluation system has been established statewide for more than ten projects. Tools to measure progress of families receiving intensive home visiting have been developed by the Montana Department of Family Services. Parents complete self-assessment questionnaires and home visitors report assessment and intervention data on a quarterly basis for entry into a central data system.

To date, the major accomplishments on a local basis include:

- strengthening ties among agencies serving vulnerable families
- enhancing family-based services: home visiting, parenting education, respite care
- parenting resources are more accessible

Program Evaluated?

Yes. Evaluation is under way with the first data report anticipated January 1996.

Would It Work Elsewhere?

Yes. Because of the benefits experienced in cooperative ventures between agencies, which extend limited resources and improve access to services.

Replicated Elsewhere?

Yes. Project includes components of other programs.

Lincoln, Nebraska

Comprehensive School Health Program

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Initiative Categories

Child Health
- School-linked/ based services

Adolescent Health
- School-linked/ based services

Access to Care
- Schools & health connections

Strengthening Public Health
- Building coalitions & partnerships

Initiative Description

"The intent of this initiative is to facilitate the meshing of school, community and family."

Lincoln, Nebraska, is a progressive and future-oriented city with community cooperation being one of its greatest assets. This sense of community was exemplified when 100 people representing diverse agencies, businesses, and groups from throughout Lincoln came together in focus groups to begin a community and school assessments of the eight components of a comprehensive school health program.

The community planning effort was co-sponsored by the Lincoln Public Schools (LPS) and the Lincoln Lancaster County Health Department (LLCHD). Through the community planning process, existing services and programs were identified. In addition, numerous gaps in and barriers to the effective utilization of these services were identified. These include lack of coordination of services, little community involvement and a minimum of integration among the eight components of a comprehensive school health program.

This initial planning effort has led to the next step, community strategic planning to "broaden and strengthen a community/school planning process that will improve and enhance coordination of existing school health programs and activities to make them more comprehensive and accessible to the school and community."

The intent of this initiative is to facilitate the meshing of school, community and family. To date, six community forums have been held and a three year strategic plan for a Comprehensive School Health Program will be completed by late September, 1995.

Funding Sources

- City/county government funds
- Public Education Foundation Network

Budget
$36,778

Partnerships

"The shared activity is a recognition that the LPS is the community leader in K-12 education and that the health department is the recognized leader in community-based health initiatives."

The Health Department and the LPS Foundation have been the leaders in the initial community planning process. The Foundation Executive Director and the LLCHD Worksite Wellness Coordinator wrote the grant to fund the strategic planning occurring now. The shared activity is a recognition that the LPS is the community leader in K-12 education and that the health department is the recognized leader in community-based health initiatives.

Lincoln, Nebraska — Comprehensive School Health Program

Leadership Enhanced?

This project has served to solidify the community recognition of the health department as a leader in assessment and planning for community initiatives relating to health. We have been leaders in many other areas, but until this effort began, our relationship with the Public Schools was fragmented and generally based on single issue problem solving rather than a comprehensive approach.

Barriers & Strategies

Barrier 1: Lack of awareness of what is going on in the community and in the school system.

Strategy 1: Community forums were formatted to heighten awareness of resources and programs, how to utilize what currently exists and build on it to fill gaps.

Barrier 2: Strong turf issues between community agencies/ groups and the school system.

Strategy 2: The community forums sought to help people see better where they fit together, not to help them see how they could do less. Not a process of taking away from anyone, but helping all to see how they compliment other services and make existing efforts more effective.

Objectives / Data / Accomplishments

The Strategic Planning Workplan consists of time limited measurable process objectives. The Plan has an extensive evaluation woven through all aspects. The primary focus is based on student outcomes. The LLCHD has conducted a Youth Risk Behavior Survey (YRBS) for the past several years. In many indices, health status for our youth is steadily deteriorating. The most current YRBS will serve as a baseline for evaluation of the Comprehensive School Health Program over the next three years.

Program Evaluated?

No.

Would It Work Elsewhere?

Yes. The planning effort is not especially costly and our town has the same turf issues that others experience. We also experience a strong community resistance to school-based clinics and it will be interesting to see if this community involvement will help build support for new systems of adolescent health care.

Replicated Elsewhere?

Yes. Seven other communities are engaged in a similar process this year.

Omaha, Nebraska

HEART: Adolescent Violence Prevention

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Initiative Categories

Adolescent Health
- Violence prevention/youth at risk

Initiative Description

"Juggling, magic, storytelling and theater help youth learn to creatively communicate about important issues and resolve personal conflicts."

HEART is an innovative health education program which employs the arts as tools for addressing the core issues associated with preventing youth violence including friendship, trust, impulse control, and anger management. Juggling, magic, storytelling and theater help youth learn to creatively communicate about important issues and resolve personal conflicts.

HEART was offered as a weekly class at a local alternative high school where youth received academic credit for their involvement in the program. A community health educator and a theater artist collaborated to provide violence prevention education. Youth examined real life problems through images they created, presented possible solutions to those problems, and discussed the potential consequences of those solutions.

HEART also offered a training for school educators and community youth program providers to learn to implement the theater activities as a tools in youth violence prevention. Individuals attended an introductory workshop designed to expose them to the techniques and to begin the process of implementing this approach with youth in the community.

Funding Sources

- City/county government funds
- General state funds
- PHHS special initiative Block Grant funds

Budget
$43,000

Partnerships

"Douglas County Health Department has taken the leadership role in developing and coordinating this program as an approach to violence prevention."

Douglas County Health Department (DCHD) has taken the leadership role in developing and coordinating this program as an approach to violence prevention. DCHD has established collaborations with a local alternative high school, University of Nebraska at Omaha health education and theater departments, the Omaha Center for the Theater of the Oppressed and the Metropolitan Arts Council.

Leadership Enhanced?

Yes. Professionals involved with youth in the community have begun to look to Douglas County Health Department for leadership as a violence prevention resource and for training others to provide violence prevention education.

Barriers & Strategies

Barrier 1: Finding professionals to integrate the arts into health education.

Strategy 1: We accessed the university community and contracted with individuals who were willing and eager to explore the possibilities.

Barrier 2: Maintain regular contact with youth to have long term impact.

Strategy 2: We moved the program to a more stable environment found in the alternative high school setting.

Objectives / Data / Accomplishments

Yes. The objective is to increase by 50 percent the number of youth who indicate an intent to choose a behavior that is an alternative to violence as a method of conflict resolution.

Data collection is done through a pretest and postest of youth to evaluate knowledge, attitudes, and behavioral intent with regards to violence. Also, individual interviews are conducted with youth to evaluate the program. Finally, observations are made on the youth to asses the impact of the program.

The major accomplishments of the program to date are that we have been able to identify that the program impacts the youth in the following ways:

- improved relationships with peer and family
- improved communication skills
- ability to think more critically
- ability to examine consequences
- ability to better manage anger and stress

Program Evaluated?

Yes.

Would It Work Elsewhere?

Yes. Community program providers who have established a trusting relationship with youth would be able to be trained to implement the activities used in HEART.

Replicated Elsewhere?

No.

Albuquerque, New Mexico

Rio Grande High School-based Clinic

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Initiative Categories

Women's Health	Perinatal Health
• Preconception health promotion	• Substance abuse prevention & treatment

Initiative Description

"The mission is to promote adolescent health by increasing access to available public health care services and promotions, and to encourage the success for students in school."

This initiative directly involves the local public health office in providing school-based services for high school students. Public health office staff are assisting by providing family planning and STD services, which were previously provided through a community health clinic adjacent to the public health office. When the community health clinic was unable to provide services, the public health department received a request to work with the University of New Mexico Maternity and Infant Project (M&I) to fill the vacated void.

Currently, a clinician from the M&I is present at the school once a week and provides general clinical services. Since contraceptives cannot be dispensed at the school, students in need of family planning services are referred to the health department for contraceptives, condoms, pills, injections, etc.

Although this initiative currently involves primary family planning services and STDs, plans are to expand for the inclusion of other services and projects with the school in the future.

Funding Sources

- Title X
- Other federal funds

Budget
NA

Partnerships

"In the planning and implementation process, collaborative efforts have been enhanced with the M&I project and the high school administration."

The partnership role involved responding to a request from the M&I program to fill the void of services that were needed in the community. In the planning and implementation process, collaborative efforts have been enhanced with the M&I and the high school administration. The entire staff at the health department is involved with some aspect of the project.

Leadership Enhanced?

Yes. The health department is viewed as a major provider for immunizations and child care services. This initiative further broadens the image of public health as a provider for the community.

Barriers & Strategies

Barrier 1: Working through a policy that doesn't allow contraceptives to be dispensed at school.

Strategy 1: The main goal to overcome this barrier is to have a process that is efficient and smooth for students. Therefore, great efforts are being made to assure that students keep their appointments and not shy away from coming to the health office for contraceptives and counseling.

Barrier 2: Working out the logistics of charting transfers and records, etc., between M&I and health department staff.

Strategy 2: A system was designed to maintain and keep files between the two offices separate, yet accessible for clinicians and health department staff. A referral process was also set up so health department staff could work with patients referred by either the health department or M&I clinicians.

Objectives / Data / Accomplishments

There are no specific objectives set, but there is a mission statement for the initiative. The mission is to promote adolescent health by increasing access to available public health care services and promotions and to encourage the success for students in school. Methods for data collection are still being developed, but the collection of data will be a collaborative effort between the health department, M&I and the school. Major accomplishments include the decision to move forward on the initiative, make necessary arrangements, train staff, rearrange schedules, order supplies and be prepared to provide services over the course of several weeks.

Program Evaluated?

NA

Would It Work Elsewhere?

Yes. The initiative demonstrates the ability of the local public health department offices to help other community organizations and entities meet a community need.

Replicated Elsewhere?

NA

New York, New York — Multicultural Community Outreach in New York City

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Initiative Categories

Access to Care
- Overcoming cultural barriers

Initiative Description

"A bilingual senior volunteer was recruited by the Chinese American Planning Council, and stationed at the NYCDOH to assist parents in Chinese and guide them through the application process..."

Based on an assessment of existing community resources the New York City Department of Health (NYCDOH) established partnerships with two community-based organizations, the Chinese American Planning Council and the New York Association for New Americans (NYANA). These organizations represent two dominant immigrant groups in New York City with the uninsured children who are eligible for the pilot project which provides access into primary and preventive health care.

A bilingual senior volunteer was recruited by the Chinese American Planning Council, and stationed at the NYCDOH to assist parents in Chinese and guide them through the application process for the health insurance program. Part-time Chinese and Russian outreach workers were hired to translate at special events for each population.

The goal of the initiative was to identify non-English speaking parents, determine the health insurance status of their children, explain the information in a culturally competent manner and enroll the child in the program. Various strategies were developed by collaborating with local businesses, clergy, community groups and schools to educate parents and enroll eligible children into the program. One particularly effective strategy was working with the foreign language media.

Funding Sources

- State general funds

Budget
$2,000

Partnerships

"...NYCDOH abdicated its role as leader and took a subordinate position to the community-based organization."

In order to implement this program the NYCDOH abdicated its role as leader and took a subordinate position to the community-based organization (CBO). It was made very clear to the CBOs and outreach personnel, both voluntary and paid, that they were the experts concerning the methods that would work in the Chinese or Russian populations.

Leadership Enhanced?

Yes. The decision to empower the CBOs and bilingual staff was effective and will serve as a model for work with other special interest populations.

Barriers & Strategies

Barrier 1: Targeting unreached immigrant groups.

Strategy 1: NYCDOH began distributing bilingual (English/Spanish) materials to promote the pilot project within specific communities. Partnerships were formed with local leaders and neighborhood agencies to develop strategies that would reach the newer immigrant groups such as Chinese and Russian families. Materials were designed, bilingual telephone operators hired and special events were organized by Chinese and Russian outreach workers to target and promote in their native tongue.

Barrier 2: Gaining trust of multicultural immigrant populations.

Strategy 2: Initially parents were not responsive to enrolling in the health plan. Relationships were built with community leaders and linkages formed with local agencies in order to encourage participation in the pilot project. Information from trusted sources such as their clergy, social workers, school teachers and other parents enabled the families to seek enrollment for their children. Overall, testimonies from the parents of enrolled children have become one of the best referral sources.

Objectives / Data / Accomplishments

Yes. The primary objective is to enroll the children of Chinese and Russian speaking parents into the pilot project. The number of fliers distributed, events planned, families who attend events and children enrolled are tracked monthly. Outreach staff submit monthly statistical and weekly narrative reports. Increased calls from the Chinese and Russian communities over a one-year period as well as a greater number of children enrolled in the pilot project are the most significant accomplishments to date.

Program Evaluated?

No.

Would It Work Elsewhere?

Yes. This initiative should be implemented in other cities and here in New York (with other health care leaders) so that language, culture, race and ethnicity are no longer health care barriers.

Replicated Elsewhere?

No.

Rochester, New York

Vision Care For Kids

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Initiative Categories

Access to Care
- Expanding private links
- School and health connections

Strengthening Public Health
- Building coalitions and partnerships

Child Health
- Children with special needs

Initiative Description

"Many of these students were uninsured, underinsured, or could not find community providers who would accept the Medicaid reimbursement rate for eye care."

The Monroe County Health Department (MCHD) School Health Program provides vision screening to approximately 18,000 students within the city of Rochester. 1990-91 school year data indicated over 1,000 students had not received treatment to correct vision problems found in screenings. Many of these students were uninsured, underinsured or could not find community providers who would accept the Medicaid reimbursement rate for eye care.

The Vision Care For Kids (VCFK) initiative was developed in two phases: Phase 1 covered a three year time frame and implemented a coordinated system to provide eye care to identified students. Phase II was concurrent with Phase I and involved a task force that developed strategies for dealing with the underlying issues of access and availability of eye-care for children.

Funding Sources

- City/county government funds
- Inkind
- United Way
- Medicaid insurance

Budget
$19,115

The community partners included the County Departments of Health, Social Services, the United Way, Lion's Club, Industrial Management Council (IMC), Rochester City School District and the Optometric and Opthamology Society. Each partner identified other linkages in the community.

The United Way purchased the lenses and enlisted the cooperation of the Health Association to coordinate the referrals and transportation needs. The process included: MCHD school personnel identified/referred students who were eligible for the program to the Health Association. The Association coordinated appointments/transportation between families and provider. Families were provided information on Medicaid HMO and Child Care Plus, a New York State supplemental insurance for uninsured, non-Medicaid eligible families.

The Phase II task force established the following strategies: increase local enrollment of eligible families in Medicaid managed care; adjust the Medicaid reimbursement rate for Vision Care services' support establish a permanent eye care fund for uninsured/underinsured students; add a vision care rider to and expand the Child Care Plus insurance to age 16.

Partnerships

"The identification of the problem, barriers to access such as transportation, language, lack of telephones were all considered in the implementation process."

The Health Department had a major leadership role in developing the initiative and continues to be an active partner. The identification of the problem and barriers to access (such as transportation, language, lack of telephones) were all considered in the implementation process. Line staff and administrative staff have participated in the Phase I and II process.

Leadership Enhanced?

Yes. Providing good data that documented the extent of the problem was critical to involving others. Providing the leadership to convince the business, professional, educational and nonprofit agencies in an initiative to address a community issue.

Barriers & Strategies

Barrier 1: Communication between collaborative members.

Strategy 1: Regular meetings of the Phase I partners to discuss concerns or issues that needed refinement to improve the process. Each partner had specific responsibilities and time lines to meet objectives.

Barrier 2: Sensitivity of eye care professionals to those being served.

Strategy 2: Some providers were not able to adapt and chose not to continue. Enlisted the assistance of the Optometric Society to do some peer sensitivity training.

Objectives / Data / Accomplishments

Data are collected annually on the number of referrals made, appointments kept and their outcomes. This data has been utilized to determine the funding required for a permanent eye-care fund.

Accomplishments to date:

- 1,534 students have received vision care follow up
- transportation has provided 1,015 door to door tips
- local enrollment of eligible families in HMO Managed Care has shown significant increases
- increased Medicaid rates has resulted in increased participation of eye care providers
- Child Care Plus has increased eligibility to age 16, however, there is no vision rider
- a permanent eye-care fund for those who are uninsured/underinsured is in the process of being established
- all partners are still committed to the initiative

Program Evaluated?

NA.

Would It Work Elsewhere?

We have found all the partners very committed to addressing the problem. Convening key personnel in the community and presenting clear data that documents the problem and root cause is vital to initial planning. All partners bought into solving the problem. They also established linkages with others.

Replicated Elsewhere?

No.

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Initiative Categories

Access to Care
- Overcoming cultural barriers
- Reducing transportation barriers
- Expanding private sector linkages

Access to Care
- Using mobile vans

Child Health
- Immunization

Strengthening Public Health
- Building coalitions

Initiative Description

"Three high risk neighborhoods were targeted. Volunteers canvassed the neighborhoods and pre-registered children when possible. Mobile vans from our ambulance service and Lead Program were utilized for on-site immunizations."

As part of the Immunization Action Plan (IAP) efforts, a retrospective kindergarten survey was completed to determine the level of age appropriate immunizations and to identify areas with low immunization levels.

Data was analyzed and the extent of our problem noted (only 50 percent were age appropriately immunized by age two). We were able to interest Success by Six, a major public/private sector initiative and become the lead community coordinator for this effort.

A professional bilingual media campaign, including TV/radio, newspaper and billboard adds was designed. Our collaboration grew to include all hospital and clinic providers of immunizations, some private sector physicians, Blue Cross Blue Shield of New York, Junior League of Syracuse Inc., American Legion Auxiliary, Hope for Kids, Eastern Ambulance Paramedics, the Syracuse School District and Syracuse City "Family Ties."

Funding Sources
- City/county government funds
- Other state funds
- Success By Six (public/private initiative)

Budget
$167,000

We developed a six month media campaign. Three high risk neighborhoods were targeted. Volunteers canvased the neighborhoods and pre-registered children when possible. Mobile vans from our ambulance service and Lead Program were utilized for on-site immunizations. Vans were parked in neighborhood play areas and balloons, clowns and music were provided. One neighborhood was primarily Hispanic and translators were provided. Our major effort will be in August when we hold our Immunization Day at the Zoo. Children eligible for immunizations, plus their families, are entitled to free zoo admissions.

Collaborators participating in these events offer volunteers for screening, immunizations, incentives, entertainment, and data collection. For the first time, we have also instituted a computer tracking system to insure that future immunizations will be administered and to link this information with ongoing providers of medical care. We also assist families in establishing a "medical home" for their children.

Partnerships

See text...

Originally the lead agency, in collaboration with Success By Six, became leader/facilitator and we provided medical, organization and recruitment expertise. Now we have many private/public partners to assist us.

Leadership Enhanced?

Gained community recognition as a community advisor, facilitator, "expert." Now sought after for participation in community health fairs, events. Lead effort for community wide immunization tracking system.

Barriers & Strategies

Barrier 1: Competition for recognition, publicity by all the collaborators.

Strategy 1: Media events press conference, press kits included information about all participants. Collaboration stressed as much as possible. Representatives were invited to all meetings/press conferences.

Barrier 2: Incorporating everyone's ideas into a viable work plan.

Strategy 2: Try different strategies, evaluate formally/informally as a group. Incorporate new ideas with "old ideas" that work. Try to give everyone a voice and an opportunity.

Objectives / Data / Accomplishments

To increase to 90 percent the number of two-year old age-appropriately immunized; retrospective kindergarten survey used for baseline information, this to be repeated annually; evaluation/stats gathered at immunization events.

Accomplishment: A community-wide immunization data base being funded, developed/utilized for tracking immunizations and lead.

Program Evaluated?

No.

Would It Work Elsewhere?

NA

Replicated Elsewhere?

No.

Charlotte, North Carolina

Mobile Solution "Bus"

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Initiative Categories

Perinatal Health
- Breastfeeding/ nutrition/WIC

Child Health
- Immunization
- Early intervention

Access to Care
- Using mobile vans, clinics for outreach

Initiative Description

"The mobile unit staff consists of a nutritionist, interviewer, medical office assistant, public health nurse II, development screener and a child care resource specialist."

The Mecklenburg County Health Department received funding to purchase a 40-foot bus to provide services for underserved populations. The mobile unit operates in conjunction with the local WIC Immunization Preschool Service and Child Care Referral programs. It functions as a remote site, utilizing a data carrier line computerized system to process applicants based on the potential number of eligible in a specified location.

The mobile unit operates four days a week and individuals are seen on a walk-in basis. The mobile unit staff consists of a nutritionist, interviewer, medical office assistant, public health nurse II, development screener and a child care resource specialist.

Prior to the arrival of the bus, staff from Mecklenburg Partnership for Children, Area Mental Health Preschool Services/Smart Start and the health department met to set policies for service provision and operation.

Criteria established to target high-risk communities by ZIP code include delinquent immunization and high teenage pregnancy rates. Site locations within the ZIP code were selected based on the need for services, safety, area security and accessibility to restrooms and parking.

Significant outreach to the targeted areas was conducted prior to the initiation of services to ensure that all potential families, health providers, community leaders and day care providers in the area were aware of the services. Currently there are 14 locations. Sites are being evaluated and different sites may be established as needs change.

Funding Sources

- MCH Block Grant funds
- State grant - Smart Start

Budget
$156,932
(includes salary & data line, maintenance& fuel provided by county)

Partnerships

See text...

The partnership role included:
- writing the original grant
- writing specifications for the vehicle
- the bid process to purchase
- designing the vehicle interior
- developing policies and procedures in collaboration with Area Mental Health Preschool Services/ Smart Start
- monitoring and evaluating services
- developing marketing, outreach plans and continual planning

Leadership Enhanced?

Yes. It allowed the health department additional ways to provide community outreach and meet the needs of the community. It will also increase visibility within communities, reinforcing the importance of services provided.

Barriers & Strategies

Barrier 1: Bid process that involved coordination with a variety of initiatives under funding constraints (two year process).

Strategy 1: Perseverance and collaborative effort, identifying deadlines and being sure that they were met. Working with a company that was not located in the community and communication was mainly by phone/fax. Getting extension of funding for an additional year.

Barrier 2: Uniqueness of initiative - no "road map" to follow.

Strategy 2: Reevaluation and reassessment of procedures. Developed collaborative team to address process and procedures.

Objectives / Data / Accomplishments

Objectives include:

- increase rate of age appropriate immunization
- increase the number of children receiving fourth DPT
- screen WIC clients
- WIC enrolled will continue participation
- children screened and referred will follow through
- identify children at risk for developmental delay

Data is collected through computer generated encounter and tracking forms.

The major accomplishment was planning and implementing a "kick-off" campaign including public relations outreach, development of schedule and delivery of bus by dealing with numerous unforeseen barriers and obstacles.

Program Evaluated?

No.

Would It Work Elsewhere?

Yes. Urban communities have similar problems, barriers and challenges (i.e., transportation, need for education, etc.). Collaboration is essential.

Replicated Elsewhere?

Don't know.

Durham, North Carolina

Health Care Credit Card Incentives

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Initiative Categories

Women's Health	Perinatal Health
• Preconception health promotion	• Prenatal care
• Family planning	• Home visiting
	• Low birthweight/ infant mortality

Initiative Description

"Preassigned point values are awarded for specific activities which promote positive behaviors which lead to good health outcomes."

The Health Care Credit Card Incentive Program is designed to help participants become more responsible for their health related behaviors. Preassigned point values are awarded for specific activities which promote positive behaviors that lead to good health outcomes.

Points with values ranging from 1-100 can be earned through the Family Planning (FP) Clinic for such things as being a nonsmoker, attending public school GED programs, delaying pregnancy for six months while enrolled in FP Clinic, compliance with method of choice, attending Male Teen session.

Points ranging in value from 1-100 can also be earned in the Maternity Clinic. Such points are awarded for activities such as attending educational sessions, keeping appointments, bringing a support person to clinic and/or educational sessions, attending HIV counseling/educational sessions, and keeping postpartum appointments.

Participants can also receive points, valuing one to three for taking care of their babies while completing activities such as enrolling/recertifying for WIC services, bringing child in for age appropriate immunizations and keeping well child visits.

Four times during the year, participants are able to shop in the Health Department's store (held in two locations) to redeem their accumulated points. Some of the items available in the store are baby items (wall clocks, lamps, cordless telephones, answering machines, AM-FM dual cassette radios) and jewelry.

Funding Sources

- City/county government funds
- Grants & donations from local organizations

Budget
$12,000

Partnerships

See text...

The staff of the department worked with other community agencies/providers to ensure community knowledge of program.

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Leadership Enhanced?

Yes, the leadership of the department has been enhanced as a result of this activity. State consultants have asked for information to replicate the program in other areas.

Barriers & Strategies

Barrier 1: Patients "working" the system to get more points than earned.

Strategy 1: Rules of the programs were changed (lost cards, etc. not replaced, points awarded by person providing services) and enforced.

Objectives / Data / Accomplishments

Yes, there are measurable objectives for this initiative. Data are collected from clinic reports regarding broken appointment rates and trimester of entry into prenatal care. From the chart audit, compliance rates can be determined. Major accomplishments have not been documented at this time.

Program Evaluated?

No. However, graduate students in a course at University of North Carolina Chapel Hill School of Public Health will be evaluating the project this year.

Would It Work Elsewhere?

NA

Replicated Elsewhere?

Yes. Chatham County Health Department, Pittsboro, North Carolina.

Greensboro, North Carolina

It's "Rite" for Guilford's Kids

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Initiative Categories

Access to Care
- Expanding private sector linkages

Strengthening Public Health
- Building coalitions and partnerships

Child Health
- Injury

Adolescent Health
- Violence prevention

Initiative Description

"Community service clubs, local hospitals and television stations created the programs and provided staffing for events."

It's "Rite" for Guilford's Kids is a multifaceted community based initiative to create awareness and provide strategies to reduce injuries to children. Community service clubs, local hospitals and television stations created the programs and provided staffing for events.

Operation Baby Buckle had provided close to 600 child safety seats to families at no charge. "Cruzin' Into Summer Safety" reached 490 families with car seat safety inspections and safety education. T-shirts and bicycle helmets were distributed to 1,000 children in 1994. During Child Health Month, health department staff teamed with gun retailers and city police departments to promote firearm safety. Pamphlets were distributed and posters were displayed in local gun shops. Local print and TV media highlighted and safety efforts.

Funding Sources

- City/county government funds
- General state funds
- Private sources
- Financial services

Budget
$40,000

Partnerships

See text...

The health department has been the key agency in developing the partnerships and in planning and implementing the interventions. It has provided administrative and program support as well as staff time for the efforts.

Greensboro, North Carolina

It's "Rite" for Guilford's Kids

Leadership Enhanced?

Yes, The Health Department managers and staff are seen as effective leaders by the community groups with whom they worked. Injury prevention is now seen by the community as a public health issue not just a public safety issue. Injury prevention is now seen by the community as a diagnosis done by health department staff.

Barriers & Strategies

Barrier 1: Financing of interventions, now donation dependent.

Strategy 1: Primerica Financial Services, which has an ongoing interest in safety, funds the seats while the health department funds staff time and incidental costs.

Barrier 2: Gun control vs gun-safety issues.

Strategy 2: Continuing efforts with retailers to educate them to gun-safety issues.

Objectives / Data / Accomplishments

No specific measurable objectives have been created. Data are collected on the number of children/parents the interventions reach. The accomplishments included close to 600 child safety seats given out at no cost, 1,000 children less than 16-years old were given bike helmets and safety instruction, 490 families were given car safety seat inspections and safety education, and their was broad print and TV coverage of gun safety issues.

Program Evaluated?

No.

Would It Work Elsewhere?

Yes. With broad community and corporate sponsorship. Business partners have marketing experience and the ability to fund projects and products necessary to the interventions. Health departments have the expertise to mobilize community efforts around identified needs within communities.

Replicated Elsewhere?

Yes. Initiative replicated in surrounding counties.

Raleigh, North Carolina

Family Centered Care

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Initiative Categories

Access to Care
- Case management

Initiative Description

"It is our belief that a FCC team approach puts the health department in good position."

Family Centered Care (FCC) is a multidiscipline team which involves the family and interventions. Teams are organized geographically to work with community leaders and other agencies in identifying resources. A lead provider works with the family at any given time. This provider may change depending on changing family needs but continuity of care by the team is assured. Other team members may be called on as consultants as specific needs arise, priorities are agreed on by the family and provider.

Clear outcomes and roles are defined in the plan of care. Contracts can be completed when needs, have been addressed, or canceled when responsibilities are not met by any party.

Wake County Human Services is re-engineering to be more collaborative. It is our belief that a FCC team approach puts the health department in a good position.

Funding Sources

- City/county government funds
- General state funds
- MCH Block Grant funds
- Medicaid insurance

Budget
NA

Partnerships

See text...

Partnerships include families, communities, mental health, social services, public schools, PTA's, parenting agencies, and private physicians and many other care organizations.

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Leadership Enhanced?

Program managers think more broadly and comprehensively. Common problems are identified and addressed more readily.

Barriers & Strategies

Barrier 1: Programmatic funding and requirements from state.

Strategy 1: FCC teams force program managers to think outside their box. Frame of reference changes from program to family. Challenge state policies. Redesign assessment and reporting forms to emphasize family.

Barrier 2: Staff perceptions of family centered care.

Strategy 2: Provide information and skill building on family involvement. Develop and revise tools and forms. Include staff in planning and piloting ideas. Challenge old ways of doing things for individuals. Include a standard of care.

Objectives / Data / Accomplishments

The objectives were:

- to increase healthful behaviors of families
- to decrease the amount of provider time and cost
- to increase the comprehensiveness of services offered families

Data are collected through case summaries, care management conferences, monthly reports family health and activities, etc.

Program Evaluated?

No.

Would It Work Elsewhere?

Yes. It does not require additional funds but rather a commitment to a different approach.

Replicated Elsewhere?

No.

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Initiative Categories

Access to Care	Child Health
• Expanding private sector links • Other outreach activities	• Immunization • Early intervention

Initiative Description

"The Center offers WIC services, childhood immunizations, development screening, expedited Medicaid, health education, TB skin tests and blood pressure screenings."

The Healthwise Center is a public health center located in an enclosed shopping mall. At this time, the Healthwise Center is open 13 hours per week from 6:00 p.m. to 8:00 p.m. on Tuesday, Wednesday and Thursday; from 11:00 a.m. to 3:00 p.m. on Saturday and 1:00 p.m. to 4:00 p.m. on Sunday.

The Center offers WIC services, childhood immunizations, development screening, expedited Medicaid, health education, TB skin tests and blood pressure screenings.

Pregnancy testing has recently been made available, although the service is not advertised. We have strenuously avoided using the word "clinic," choosing instead to emphasize a broader array of services.

We have only held one-day immunization events at area malls for three years. When we expressed our wish for more than one session a year, one of the malls responded, "Why not?" The mall donated a vacant store and utilities for a one-year trial period. Staffing for the Center is shared among the county's three local public health departments and WIC.

Funding Sources

- City/county government funds
- Other federal funds

Budget
$100,000
(plus in kind space)

Partnerships

"A computer was donated by GenCorp through our Junior League connections."

The county's three public health departments jointly planned and implemented this activity in cooperation with Rolling Acres Mall. The county Department of Human Services also helped with some of the furniture. A computer was donated by GenCorp through our Junior League connections.

Leadership Enhanced?

The Healthwise Center has enhanced the image of public health in the community by bringing services out to the public rather than making them come to us. We hope to add other services as time goes on.

Barriers & Strategies

Barrier 1: No one individual or agency has sole responsibility for the project.

Strategy 1: Nursing leaders from the three health departments meet regularly to work out problems and issues. We hope to find funding for a coordinator in the future if the project continues.

Barrier 2: We have no funds for publicizing the center.

Strategy 2: We worked with the mall staff and their public relations consultant to stage a kickoff ribbon cutting which was attended by state and local officials. This received both television and newspaper coverage. We are currently working on developing other plans for publicity, possibly including other health observances such as lead poisoning awareness week, etc.

Objectives / Data / Accomplishments

A "Superbill" is used to record clinic service encounters. WIC keeps separate records for their clients. No formal objectives were set. Services delivered for the first 135 days of operation included:

- 374 client encounters (WIC)
- 436 client encounters (nursing)
- 583 immunizations given
- 99 blood pressure screenings
- 32 development screenings
- 39 TB tests

Program Evaluated?

No.

Would It Work Elsewhere?

This initiative would work but only with generous cooperation from the mall management and owners. Our mall management sold the idea to the out-of-town owners. Health departments must commit to staffing on weekends and evenings.

Replicated Elsewhere?

No.

Columbus, Ohio

Assessment of Immunization Status

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Initiative Categories

Child Health
- Immunization
- Children w/ special health care needs

Access to Care
- Expanding private sector links

Strengthening Public Health
- Building coalitions
- Immunization tracking/recall

Initiative Description

"The primary goal was to establish baseline data to encourage providers to evaluate the immunization status of their patients and provide appropriate interventions."

The Columbus Health Department (CHD) conducted immunization assessments of a random sample of private physician practices and all clinics receiving public vaccine in Franklin County in 1993. The Centers for Disease Control and Prevention (CDC) immunization assessment methodology was utilized. Assessment of immunization status in a practice is the main indicator of how well recommendations for childhood immunization administration are implemented. It also provides early indicators for the presence of significant barriers to immunization.

Thirty-three physician practices participated for a response rate of 59 percent. The overall percentage of children up to date by age two was 46 percent in the private sector and 32 percent in the public sector.

The primary goal was to establish baseline data to encourage providers to evaluate the immunization status of their patients and provide appropriate interventions. The results were shared with the community and presented to the physician community at the CME Conference held at Children's Hospital.

The assessment is currently being repeated in 1995 using Clinic Assessment Software Application (CASA) provided by the CDC. The capabilities of this program greatly increases the efficiency of data collection and analysis.

Funding Sources

- City/county government funds
- Other federal funds

Budget
NA

Partnerships

"This program supports the partnership of Project L.O.V.E.!...

...to increase the number of children fully immunized by the age of two."

The CHD Immunization program designed and implemented the study using methodology established by CDC. This program supports the partnership of Project L.O.V.E.! (a private/public partnership established in Franklin County among Franklin County Hospital Council) Franklin County, Columbus Health Departments, physicians, and community groups to increase the number of children fully immunized by the age of two. Currently the CHD is repeating the original assessments done in 1993 and offering the assessment to additional practices. In collaboration with Children's Hospital, self-study guides are being developed for the staff of physician offices with possible CME and CEU credits offered.

Leadership Enhanced?

Yes. It has helped to form a collaborative, cooperative relationship with physician practices and public providers of immunizations in a community effort to raise immunization levels.

Barriers & Strategies

Barrier 1: Convince physicians of need to assess their practices and the additional work required of their office staff to complete the survey was necessary and beneficial.

Strategy 1: Incentives such as in-services for physicians and staff were offered as well as Project L.O.V.E! materials such as magnets, buttons, posters and stickers.

Barrier 2: Establishing with each provider assessed a random sampling of two-year olds in that practice.

Strategy 2: Worked with each practice individually to establish a list of patients served. This was time consuming since some practices did not have a computerized data base.

Objectives / Data / Accomplishments

Yes. Found in description of the initiative. Almost 300 pediatricians and family practitioners were identified in Franklin County who served children two years of age or younger. Practices were randomly selected. Initiative was also presented as an abstract at the 28th National Conference in North Carolina.

Program Evaluated?

Yes. By CDC National Immunization Program.

Would It Work Elsewhere?

Yes. Methodology is standardized. CDC has stated "What Gets Measured Gets Done?" Showing practices that their rates are not 90 percent encourages them to evaluate their practice methods and explore ways to remove the barriers to immunizations.

Replicated Elsewhere?

Yes. Colorado and Connecticut Immunization Programs.

Dayton, Ohio

Teen Parent Program

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Initiative Categories

Child Health
- Expanded child health services

Adolescent Health
- Teen parenting

Access to Care
- Increasing social support systems
- Case management

Initiative Description

"...the program's goal is to offer home-based social services to teen parents so they can be more successful parents."

Teen parent program has been a collaborative effort of the Combined Health District (CHD) and the Family Service Association (FSA). Teen parents, besides facing the stress of parenting, usually lack the internal and external resources to meet the demands of raising children. As cited in the 1993 profile, the program's goal is to offer home-based social services to teen parents so they can be more successful parents.

The program has been in operation for almost two years. As teen parents bring their children for in pediatric health care, CHD refers them to FSA for home-based services. The services offered by FSA are counseling resource referrals, parenting skills, group support and mentoring. As teen parents availed themselves to services, they have developed better parenting skills and resources which have created healthier, safer and more nurturing home environments for their children.

One hundred and fifteen (115) teen parents have been referred within the first year and a half. Referrals come from two innercity pediatric health centers with similar economic recovery profiles. Fifty-two (52) families have accepted FSA services; 53 have declined services and 10 are pending. The outcomes from FSA services have been positive resulting in the teens being more successful parents.

Funding Sources

- City/county government funds

Budget
$25,000

Partnerships

"...both the Combined Health District and Family Service Association have shared responsibilities in planning and implementing the program."

From the onset of the teen parenting initiative, both CHD and FSA have shared responsibilities in planning and implementing the program. The evolution of the teen program has taken CHD from the concept stage, to actually identification families for referral, to offering services, to evaluation of services and the redefining of roles and service delivery.

Dayton, Ohio

Teen Parent Program

Leadership Enhanced?

For more than five decades, the combined Health District has been recognized as a leader in being involved with providing services to the most vulnerable and needy citizens in the community. This endeavor further enhances that reputation.

Barriers & Strategies

Barrier 1: Lack of clear expectations of service delivery based on need.

Strategy 1: Case conferencing enabled CHD and FSA to define expectations and roles. This barrier could be part of the normal growth when two agencies with different orientations joined together to address a need. The conferencing allowed fine staff workers to understand each agencies expectations of success and the avenues to reach those goals. The agency's had the same general goal of enhancing parenting but how to develop responsibility within the teen parents seemed to be the key issue.

Barrier 2: Teen nonacceptance of social services beyond medical.

Strategy 2: Some teen parents were not accepting of FSA services due to lack of trust. Both agencies worked on approaches of selling the teen program. CHD and FSA worked on identifying specific concrete needs of the children so the teen parent could latch on to the value of FSA services and allow trust to be developed.

Objectives / Data / Accomplishments

Successful parenting is a subjective statement. CHD used measurable objectives of:

- no show rate
- compliance of physical exams and immunization
- use of WIC and Medicaid programs as factors for success. The data was collected by individual chart review. There were three groups reviewed: a baseline group of teen parents from 1992 who were not involved with the initiative; teens accepting service and those declining. The first year and a half showed no-show rates slightly lower for families involved with FSA. Teens using FSA services had significantly higher compliance in physical exams and immunizations being up-to-date. FSA families also showed a much higher utilization of WIC and Medicaid programs. Teen parents involved with FSA seem to be more successful in their parenting.

Program Evaluated?

Would It Work Elsewhere?

No.

Yes. The intent of the initiative was straightforward. Two agencies which offer services to the same population. Working jointly with a defined group to enhance service delivery. All communities have teen parents who are in need of child health care and supportive services to assist in their parenting success.

Replicated Elsewhere?

No.

Clevland, Ohio

Immunization Action Plan

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Initiative Categories

Child Health
- Immunization

Initiative Description

"Build a vaccine delivery system to sustain these achievements..."

The Immunization Action Plan was developed to:

- reduce most childhood vaccine preventable diseases to zero
- increase vaccination levels for two year old children (most vulnerable)
- build a vaccine delivery system to sustain these achievements
- improve the quality and quantity of vaccination delivery services
- reduce vaccine cost for parents
- increase awareness
- improve vaccines and vaccine use
- increase community participation and expand public and private partnerships
- immunization Action Plan - Grants awarded to local health departments forcollaborative efforts to improve immunization rates through improving access, services, and compliance through education
- vaccines for Children Program (VFC) - free vaccines available through participating agencies and qualifying families and children

Funding Sources

- Other federal funds

Budget
$524,000

Partnerships

See text...

Lead agency forming collaborative with public and private direct service providers, WIC, All Kids Count, Registry and Reminder Technology, community service groups, schools, Head Start, Healthy Family/Healthy Start, businesses and grass roots community leaders.

Leadership Enhanced?

Yes. This formerly dominant health issue in now a buzz word around the greater Cleveland community. The Cleveland Department of Public Health is recognized as the central coordinating impetus for the immunization initiative.

Barriers & Strategies

Barrier 1: Ignorance of the problem and poor immunization rates among parents, health care providers, and general public.

Strategy 1: Education, dissemination of educational materials, formation of collaborative consortium of activities, and networking with compatible community programs.

Barrier 2: Poor accessibility and availability of free immunization services to those who need them (uninsured).

Strategy 2: Establishment of convenient satellite clinics across the greater Cleveland area providing accessible locations and times for families to bring children for free immunizations.

Objectives / Data / Accomplishments

Data is collected through regular state-required immunization records. Additional specific data is used to make decisions regarding the focus of activities and services to promote timely immunizations. Data shows a trend of rising immunization rates and greater community recognition of the need for timely immunizations.

Program Evaluated?

Yes. Through report procedures and site visits.

Would It Work Elsewhere?

Yes. It is already being implemented nationally.

Replicated Elsewhere?

Yes. Nationally.

Oklahoma City, Oklahoma

Early Start and Early Testing Early Care

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Initiative Categories

Women's Health
- Preconception health promotion
- Family planning

Perinatal Health
- Prenatal care

Adolescent Health
- Teen pregnancy

Access to Care
- Expanding private sector linkages

Initiative Description

"Early Start provides immediate access to oral contraceptives for up to three months with a limited exam and history."

The epidemic of unintended pregnancies has become a major health issue in our state. We have recognized for some time that teen pregnancies and teen births in Oklahoma are a major problem. However, the unintended pregnancy rate among women twenty years of age and older is greater than three times that of teens. Because of this data and knowing the long wait times for family planning appointments, the implementation of the Early Start program was authorized.

Early Start provides immediate access to oral contraceptives for up to three months with a limited exam and history. The purpose is to offer contraceptive protection to women until an appointment can be made at which time a complete examination will be done. This program has the potential to decrease significantly unintended pregnancies in Oklahoma.

The idea of a deferred physical examination to begin oral contraceptives was recently addressed by the Food and Drug Administration's Fertility and Maternal Health Drugs Advisory Committee. The Committee recommended to the FDA that oral contraceptive labeling be revised to permit the provision of oral contraceptives prior to a physical examination. Oklahoma has received notification, from the office of Population Affairs, that the current Title X policy that requires a physical examination before oral contraceptives are issued may be waived for this pilot program.

Funding Sources

- City/county government funds
- MCH Block Grant funds
- Medicaid

Budget
NA

We combined Early Start with our Early Care program. The purpose of the Early Start project was to develop a pregnancy testing program which links women to a system of care, allowing those with positive tests to access early maternity care, and those with negative tests to access family planning services. All women requesting pregnancy testing are given counseling depending on the results of the test. Those who have a pregnancy test, are followed up to determine whether they obtained further services and their satisfaction with that service.

Partnerships

See text...

A collaborative partnership is demonstrated with programs and services in our community, by partnering with community colleges, universities, and vocational technical schools, as well as low income housing projects and several perinatal nonprofit clinics.

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Leadership Enhanced?

Yes. Recognition by state health department and utilized as an example to statewide county health departments. It has been enhanced because we are the only agency providing this service.

Barriers & Strategies

Barrier 1: How to effectively integrate into busy clinic.

Strategy 1: Staff education, preparation, and input clinic flow changes. Assigning one specific public health nurse per day to do only Early Start until all were comfortable with the new program. Eventually we were able to integrate the "drop-in" appointments into scheduled clinic operations.

Barrier 2: Limited site availability makes transportation difficult.

Strategy 2: Due to limited site availability, clients from partnered programs have to travel to main clinic for services; contacts are being made with other community agencies to negotiate on site services for them.

Objectives / Data / Accomplishments

Yes, to increase first trimester entry into prenatal care and decrease unintended pregnancies. Data are collected and tabulated to track: race, age, negative and positive contraceptive methods failure, no method, or planned, tracking of referrals, and number of women applying for Medicaid. A follow-up is done on each woman as well.

Accomplishments: because of it's popularity, an expansion of both programs has been instituted. An increase in both maternity and family planning appointments has been documented, as has an increase in the number of women entering first trimester prenatal care.

By adhering to Title X guidelines in providing pregnancy diagnosis and options of counseling to those women in need of this service, topics of counseling are:

- importance of early prenatal care and good nutrition
- desire for sterilization at time of delivery
- Medicaid eligibility
- adoption
- social worker referrals
- dangers of smoking and alcohol or drug use
- WIC
- preconception health issues
- pregnancy termination
- contraception.

Program Evaluated?

Yes.

Would It Work Elsewhere?

NA

Replicated Elsewhere?

No.

Portland, Oregon

Postponing Sexual Involvement (PSI)

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Initiative Categories

Adolescent Health
- Teen pregnancy

Initiative Description

"PSI utilized high-school teen leaders to deliver a structured program designed to build sixth-grade students' ability to refrain from sexual activity."

During the 1994-95 school year, the Multnomah County Health Department (MCHD) initiated a demonstration project entitled "Postponing Sexual Involvement" (PSI) in four Portland, Oregon middle schools. The project was based on Postponing Sexual Involvement; an educational series for young teens developed by Marian Howard and Marie Mitchell for Atlanta's Grady Memorial Hospital.

PSI utilized high school teen leaders to deliver a structured program designed to build sixth-grade students' ability to refrain from sexual activity.

The program focused on the message, "Its best for teens not to be sexually involved?"

Specific objectives for participants included: 1) identifying the risks of sexual involvement; 2)understanding social pressures and the right to refuse, and 3) developing assertiveness skills to resist sexual involvement.

The curriculum was presented by 17 teen leaders to 807 sixth-grade students in four schools. Another 561 students in two other schools served as a comparison group. Each of the teen leaders was trained through a 20 hour Training Retreat.

Preliminary evaluation results revealed a high level of support for the program on the part of students and school staff. Results suggest that students learned the intended content. Based on these results, MCHD received funding from the County Board to expand the program to 15 middle schools or half of the middle schools in the county with a promise of funding next year for the other half.

Funding Sources

- City/county government funds

Budget
NA

Partnerships

See text...

The department has been responsible for planning and implementation of the program, with the administrative and political support of the Portland Public Schools.

Leadership Enhanced?

The leadership of the Department has been enhanced in:

- developing another form of cooperative activity with the schools
- providing effective and visible leadership for primary prevention of teen pregnancy

Barriers & Strategies

Barrier 1: Obtaining initial funding.

Strategy 1: Project was funded by a grant from Multnomah County's Children & Youth Commission. This was difficult because there were expectations that these grant funds should be earmarked for community organizations involved in teen parent support, not primary prevention.

Barrier 2: Grant funds released very late, so need to implement project very rapidly.

Strategy 2: Skilled staff with experience with PSI in another community were hired, allowing rapid implementation.

Objectives / Data / Accomplishments

PSI is based on achieving measurable reductions in teen sexual activity and teen pregnancy among participating teens. Formal evaluation of the project is ongoing at this time (August 1995). Data gathered includes written surveys of participants and comparison of student groups and qualitative assessments of process. Many of these measures were performed at baseline and later repeated for follow-up. Data are being used for both formative and summary purposes.

Program Evaluated?

NA

Would It Work Elsewhere?

Yes. This initiative would likely work well in other communities. It is relatively straightforward to administer. It can enjoy wide political support due to its preventive nature, and its emphasis on young people avoiding sex rather than mitigating the impact of sex.

Replicated Elsewhere?

Don't know.

Salem, Oregon

Child Health Initiative

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Initiative Categories

Child Health
- Expanded child health services

Access to Care
- Increasing social support systems
- Case management

Strengthening Public Health
- Reshaping financing for MCH
- Building coalitions

Initiative Description

"The key elements of the project are care coordination, and decategorization and leveraging of funds."

Marion County has several school attendance areas where over 75 percent of the families fall below the Federal poverty guideline. In two of these schools, the Marion County Health Department entered into a collaborative partnership with families, neighborhoods, schools, local and state government, private health care providers and the Robert Wood Johnson Foundation (RWJ) to improve low income children's access to health and social services.

The key elements of the project are care coordination, and decategorization and leveraging of funds. There are eight such pilot projects in the nation. The Marion County site, alone, appears to have been successful in decategorizing and leveraging funds.

Care coordinators works with families in the schools or in their homes. They help families get comprehensive screening, as assessment and planning for their children.

De-categorization and leveraging of funds in order to provide staffing and health insurance coverage for children who are not eligible for other coverage. Partners pledged $318,000/year in cash, in kind and direct service resources to the initiative. Salaries of school district staff who provide health access to students was matched by federal Medicaid funds, increasing the size of the pool.

An annual report card is completed to demonstrate the achievement of the objectives of the initiative.

Funding Sources

- City/county government funds
- Robert Wood Johnson start-up grant.

Budget
$583,673

Partnerships

"The Health Department provided staff to coordinate and write the RWJ proposal and to act as staff facilitator..."

The Health Department facilitated bringing the various players together, brought out state support and RWJ support. The Health Department provided staff to coordinate and write the RWJ proposal and to act as staff facilitator of various needed activities to get the partners involved, committed and participating.

Leadership Enhanced?

Yes. It has opened other avenues for other collaborative endeavors. For example, a new van with dental services was made possible through a variety of partners.

Barriers & Strategies

Barrier 1: Assuring ongoing partner participation and commitment.

Strategy 1: Developed a broad based community policy board. They meet monthly and are responsible for the policy development and oversight.

Barrier 2: Obtaining ongoing funding not to rely on RWJ.

Strategy 2: Developed Medicaid leveraging plan which will allow not only continuum of current project at two school sites, but also expansion to two more sites even with termination of RWJ.

Objectives / Data / Accomplishments

Measurable objectives as reflected in the annual "report card" include:

- data collected are related to services provided
- all children in project schools are up to date on immunizations
- all children have a "medical home"
- dental services have been arranged to be available to all children
- all children who ride bikes have received free bicycle helmets
- all families have received free smoke detectors and batteries

Program Evaluated?

Yes.

Would It Work Elsewhere?

Yes. The same resources are there because the basic resources were used. All areas have access to Medicaid.

Replicated Elsewhere?

Yes. In the eight other project sites.

Philadelphia, Pennsylvania

Breastfeeding Promotion Initiative

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Initiative Categories

Perinatal Health	Child Health
• Expanding maternity service • Breast-feeding/ nutrition/WIC	• Early intervention

Initiative Description

"...Philadelphia Department of Public Health, Office of Maternal and Child Health (MCH) prepared and disseminated a breast-feeding policy statement in 1992 that recommended breas-feeding as the best choice for infant feeding..."

In response to low rates of breastfeeding, the Philadelphia Department of Public Health, Office of Maternal and Child Health (MCH) prepared and disseminated a breast-feeding policy statement in 1992 that recommended breast-feeding as the best choice for infant feeding. In 1994 a certified lactation consultant was hired part-time by MCH to implement this policy and develop related activities, particularly in a hospital setting, designed to promote breast-feeding.

During fiscal year 1995 (July - June 1995), MCH's lactation consultant "adopted" the Medical College of Pennsylvania, a University hospital and teaching institution, to provide intensive training and on-site assistance to increase its rates of breast-feeding. This assignment included: training nursing students to foster breast-feeding by new mothers; conducting in-services for medical students and physicians; providing technical oversight in the rewriting of the hospital's policies that affect breast-feeding.

Additional activities during FY95 included: leading inservices at six additional Philadelphia-area hospitals; preparing and disseminating three issues of "Breast-feeding Times" a newsletter for hospital staff; updating and distributing more than 1,000 copies of the Philadelphia Breast-feeding Resource Handbook; coordinating quarterly meetings of Breast-feeding Work Group that includes representatives from 13 hospitals; distributing plastic tote bags with a positive breast-feeding message ("Breast is Best") to area hospitals; distributing a motivational video tape featuring Anita Baker affirming the choice to breast-feed; preparing, selecting, translating and distributing technical and consumer education materials.

Funding Sources

- MCH Block Grants

Budget
$33,600

Partnerships

"The office of MCH has brought together representatives from all corners of Philadelphia's breast-feeding community..."

The office of MCH took the initiative to develop the breast-feeding policy and support its implementation. The Office of MCH has brought together representatives from all corners of Philadelphia's breast-feeding community, serving as a hub for networking, planning and support.

Leadership Enhanced?

Yes. The office of MCH has been recognized by Philadelphia's breast-feeding community, as well as by area hospitals and providers, as the central resource for accurate, comprehensive and culturally competent information, referral and technical assistance regarding breast-feeding.

Barriers & Strategies

Barrier 1: Aggressive distribution of formula by companies.

Strategy 1: Through MCH's own aggressive efforts, breast-feeding has increased its visibility among pregnant and postpartum women. In addition to the improved promotion of breast-feeding by hospital and provider staff, the distribution of "Breast is Best" plastic tote bags to new mothers and motivational video tapes to hospitals and clinic waiting rooms has introduced a powerful message in support of breast-feeding.

Barrier 2: Resistance due to uncomfortableness and/or fear of it.

Strategy 2: MCH's lactation consultant has made numerous presentations to individuals and groups designed to remove the stigma of breast-feeding, and to educate women about its physical and psychological benefits. Breast-feeding is promoted as a safe, clean and easy way of infant feeding that creates a special closeness between a new mother and her baby.

Objectives / Data / Accomplishments

The principal objective of this initiative is to increase the percentage of new mothers who breast-feed primarily anecdotal and through regular observation of new mothers at area hospitals and health care facilities. Accomplishments to date include the education of professional staff, and an increased visibility of breast-feeding as an option. In addition, the office of MCH has established itself as the central resource for breast-feeding information in Philadelphia. Long-term benefits to increased breast-feeding-- a decrease in SIDS deaths, for example--will not be observed for several years.

Program Evaluated?

No.

Would It Work Elsewhere?

Yes. With cooperation of local hospitals and other health providers, MCH's breast-feeding initiative could be replicated wherever there is commitment to promote breast-feeding as the best choice for infant feeding. All that is required is a dedicated staff member who can educate the community about breast-feeding benefits.

Replicated Elsewhere?

No.

Pittsburgh, Pennsylvania

Resource Mothers Project

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Initiative Categories

Perinatal Health	Access to Care
• Expanding maternity services	• Overcoming cultural barriers
• Home visiting	• Reducing transportation barriers
• Low birthweight/ infant mortality	• Case management

Initiative Description

"The Project is designed to reduce infant mortality, promote early enrollment in prenatal care and improve the utilization of available health and social services."

The Resource Mothers (RM) Project is an intensive outreach initiative to pregnant women and teenagers and their infants in three high-risk communities. The Project is designed to reduce infant mortality, promote early enrollment in prenatal care and improve the utilization of available health and social services.

Staff consists of lay home visitors (RM), social workers, and a nurse. The RM are all mothers with low-income backgrounds who have themselves been WIC participants. The professional staff and RMs work as a team with the RM having the primary relationship with each family.

The RMs visit each family at least monthly from enrollment until the infant is one year of age. They assist women to obtain health care for themselves and their infants and to carry out the recommendations of the health care providers, facilitate entry into WIC, etc., promote parent-infant bonding and infant development and support school attendance, job training, etc.

Funding Sources

• MCH Block Grant Funds

Budget
$375,000
($2,060/client served)

Partnerships

See text...

Partnerships have developed between the department and a prenatal clinic located in the largest targeted community, and between postpartum/infant follow-up programs there toward a coordinated follow-up system that serves all families with infants in these neighborhoods.

Pittsburgh, Pennsylvania

Resource Mothers Project

Leadership Enhanced?

The leadership role has been enhanced through this demonstration project employing low-income mothers to mentor other low-income families. This was a new approach in our County.

Barriers & Strategies

Barrier 1: Employing lay home visitors and professional staff to work together as a team.

Strategy 1: By providing common orientation and training and including sessions on team building, conflict resolution, etc., and supporting all staff members and promptly addressing all concerns expressed by the staff.

Barrier 2: The county personnel system prohibited hiring mothers exclusively as lay home visitors.

Strategy 2: By contracting with a local private, nonprofit agency for the RM. This agency provides attitudinal and job skills training for welfare dependent individuals.

Objectives / Data / Accomplishments

The RM Project has measurable objectives. Data are collected by project staff, compiled and analyzed to inform decisions regarding project management and services. In the first year since the project was fully implemented, entry into prenatal care during the first trimester improved 11.2 percent in the target communities, compared to 2.1 percent in the county. However, first trimester care is still occurring suboptimally in the target communities (77.5 percent, 97.3 percent in the county in 1994). There were eight infant deaths in the target communities in 1993 and only three in 1994. The low birthweight rate has remained high (10.1 percent in the target communities, 7.9 percent in the county in 1994).

Program Evaluated?

No.

Would It Work Elsewhere?

The RM would work provided the RM's role is planned carefully, services are structured and RMs are closely supervised. Addressing the transportation needs of RMs and clients is also critical. Various incentives and group activities also helped to engage clients.

Replicated Elsewhere?

Yes. Norfolk, Virginia and other communities.

Knoxville, Tennessee

Hepatitis B Prevention Initiative

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Initiative Categories

Child Health
- Immunizations

Initiative Description

"...initiated a joint effort to protect as many teens as possible from Hepatitis B through a school based immunization effort."

Knox County has experienced a consistent number of teens with sexually transmitted diseases, especially gonorrhea and chlamydia, along with a constant teen pregnancy rate of 20 percent.

These rates would indicate an increased risk for exposure to hepatitis B, even though reported cases in this age cohort are very small. Health Department and Board of Education health personnel initiated a joint effort to protect as many teens as possible from Hepatitis B through a school based immunization effort.

Funding Sources

- State funds for vaccine
- County funds for nursing, clerical staff & supplies

Budget
NA

Partnerships

"Initiate dialogue... provide vaccine... coordinate record keeping..."

The Knox County Health Department role was to initiate dialogue with public school health personnel, provide vaccine for immunization effort and coordinate record keeping, supplies and information backup to parents and community.

The health department had been provided vaccine through a statewide initiative for high risk adolescents and teens. The vaccine was available without charge to those teens who presented at clinic, but we believed that we needed a greater prevention effort.

Leadership Enhanced?

The response to this initiative far exceeded our expectations. We had hoped to vaccinate 600 to 800 teens. We actually gave 6,000 first doses and 5,494 second doses. Many parents called to commend our efforts and there were requests from private schools for a similar initiative.

Barriers & Strategies

Barrier 1: While not a barrier to implementation, the initiative was limited by lack of funds for vaccine to expand to private schools.

Objectives / Data / Accomplishments

The short-term objective to immunize as many teens as possible through this project resulted in 44 percent of the students in public high schools being given vaccine. The long-term objective of preventing Hepatitis B will prove to be somewhat difficult to assess, but hopefully this effort, along with other interventions, will result in a decreased number of Hepatitis B cases and carriers in our community.

Program Evaluated?

No.

Would It Work Elsewhere?

Yes. Providing funds where available for vaccine and staff. Prevention of Hepatitis B through vaccine efforts is relatively easy to replicate and increased awareness of this disease enhances the public receptiveness to such efforts.

Replicated Elsewhere?

NA

Memphis, Tennesse

Adolescent Hepatitis B Vaccination

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Initiative Categories

Adolescent Health
- School-linked/ based services

Other Outreach
- Communicable diseases

Access to Care
- Schools & health connections

Initiative Description

"Ultimately targeted groups were children of health department employees, known regular patients at the reproductive health clinic... and school based clinics."

The State of Tennessee had about 20,000 doses of Hepatitis B vaccine to be dispersed across the state through local health departments. Approximately 2,500 doses were assigned to Memphis and Shelby County Health Department (MSCHD), the target group was adolescents aged 11-19. A number of high-risk groups were identified but there was significant differences in the ability to follow up for completion of the series, e.g., adolescents in the Juvenile Justice System for dose one and two may not respond for dose three once out of the system.

Ultimately targeted groups were: children of health department employees and known regular patients at the reproductive health clinic who met the criteria, but the largest group came from the school-based clinics; and it is this group that the profile addresses. About 400 pupils participated from each school representing about two-thirds of the student population.

Funding Sources

- City/county government funds
- General state funds, vaccine provided by state, supplies provided by MSCHD

Budget
$220,000

Student nurses from the RN-BSN program at a local school of nursing were looking for a project for their senior leadership experience which would involve about 200 hours work per semester for two semesters, (different students each semester). It was suggested that they plan, coordinate and implement the Hepatitis B vaccination initiative. First semester students planned, gathered incentives and held preliminary meetings with school principals and administrators. They worked closely with health department personnel to develop protocols, procedures and information letters. They also recruited students from the schools. Art students and their teacher developed posters for display at one school, music students and their teacher devised and produced a rap video which was used at both schools.

Second semester students were thoroughly briefed by first semester students and enthusiastically presented educational materials at faculty meetings. Additional information was conveyed over Channel 8 television. These students then coordinated the administration of first and second doses. The implementation also involved students in their Public Health rotation and their faculty. There was a high response to the second shot. The third shot clinic will be planned and coordinated by different students taking the leadership course this fall.

Partnerships

"See text...

Initiator, provider of supplies, consultant, and collaborator, in partnership with the Loewenburg School of Nursing, University of Memphis (implementor) and the State of Tennessee Department of Health (vaccine provider and initiator).

Leadership Enhanced?

Yes - It has enhanced the perception of the health department and of the role of public health for nursing students and faculty - they have a new awareness of the role of public health in prevention of disease. It has opened up new pathways for cooperative efforts - in July a three-day preschool physical and vaccination initiative, with our support and collaboration in planning and setting up, but completely operated by faculty and students.

Barriers & Strategies

Barrier 1: Original perception of parents of these mostly African-American adolescents that their children were being used as guinea pigs.

Strategy 1: Education about Hepatitis B vaccine and its effectiveness; that it is not a research medicine. Information about other groups that the offer is being made to the children of all health department employees and they are enrolled in the initiatives; that anyone meeting the criteria who is a regular health department client, i.e., likely to complete the series, will be offered the opportunity to participate.

Barrier 2: The original barrier was what sparked this school-based clinic initiative, i.e., how to target people who met the criteria and were likely to complete the project.

Strategy 2: A) Offered to all health department employees for their children; B) Targeting the pupils at the two schools with school-based clinic; C) Targeting regular clients who meet the criteria and attend a health department clinic or program.

Objectives / Data / Accomplishments

Yes. The end objective is to complete the series on all adolescents who enter the initiative; data is collected through a paper trail and data entry; 400 students registered and initiated in the program in each school. Students are "connected" to the program. Moms whose kids missed the school opportunity have brought them to the clinic and requested the shots. Smaller groups of employees children and women's health clients in neighborhood clinics, who meet criteria, are also immunized.

Program Evaluated?

Yes. By the students as part of their project. Changes have been made based on the evaluation. Evaluation is ongoing.

Would It Work Elsewhere?

Yes. For those with schools of nursing, this is an excellent senior project which is tailor made to fit the needs of the department and the educational institution.

Replicated Elsewhere?

NA

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Initiative Categories

Perinatal Health
- Breast feeding/ nutrition/WIC

Child Health
- Immunization
- EPSDT screenings

Access to Care
- Reducing transportation barriers
- Housing/health connections
- Mobile vans/ clinics/outreach

Initiative Description

"Services include nutrition education, immunizations, social service referrals, health promotion, education activities, issuance of food vouchers and health assessment."

A specially equipped WIC mobile unit was purchased to provide outreach services to community sites. The homeless population is an important group that is now being provided services through the WIC mobile unit. The unit is equipped with two private interview areas and an exam room. The unit is used Tuesday through Friday and on weekends.

Services include nutrition education, immunizations, social service referrals, health promotion, education activities, issuance of food vouchers and health assessment.

The mobile unit will provide services at a rural health center, which was destroyed by a fire, twice a month until the center is rebuilt.

Funding Sources

- Other federal funds
- WIC community development block grant

Budget
$140,000

Partnerships

"The WIC mobile unit has enabled the health department to link with other service providers in new ways."

The health department initiated the proposal for the WIC mobile unit. To secure funding, the health department had to work closely with city administration and the Texas Department of Health. The WIC mobile unit has enabled the health department to link with other service providers in new ways.

Austin, Texas

WIC Mobile

Leadership Enhanced?

The health department has expanded its leadership role in bringing WIC services to the community. New partnerships are forming as a result of this new initiative. For example, WIC staff are considering providing WIC services to child care centers serving large numbers of low-income families with the mobile unit.

Barriers & Strategies

Barrier 1: Funding for initial purchase and operations.

Strategy 1: This barrier was overcome by combining several funding sources including Dispro, a community development block grant and WIC funds. WIC discretionary funding will be used for operations for the next 18 months.

Barrier 2: Reluctance of some locations to allow the van to park and provide services.

Strategy 2: Through networking and personal contacts, many sites are now allowing operations. A proven track record promotes our success.

Objectives / Data / Accomplishments

WIC computer system monitors the number of encounters and demographics.

The goals are to:

- increase the number of homeless families in shelters and motels served
- increase WIC, immunization and EPSDT services at housing authority sites
- increase WIC outreach to previously unserved areas

The major accomplishment to date is the services provided to homeless families. Extensive referrals have been given and a new "homeless" food package has been developed for WIC.

Program Evaluated?

NA

Would It Work Elsewhere?

Yes. Those in greatest need of services often lack transportation and documentation to access WIC in traditional settings.

Replicated Elsewhere?

Yes. El Paso, Texas.

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Initiative Categories

Access to Care	Perinatal Health
• Expanding private sector links	• Home visits
• Other outreach activities	**Strengthening Public Health**
• Case management	• Building coalitions

Initiative Description

"...family is the cornerstone of community health and education can reach families in a non-threatening, familiar atmosphere...

...public health nurses began working to empower and motivate families in their homes..."

Over the last two decades, MCH nursing has become a specialty and clinic based rather than a generalists practice, with home visits, reserved for high risk families. The advent of health reform, increased client health care options has caused re-evaluation of the way MCH nurses are utilized within the core public health functions of assessment, policy development, and assurance.

Recognizing that the family is the cornerstone of community health and that education can reach families in a non-threatening, familiar atmosphere, city of Dallas public health nurses began working to empower and motivate families in their homes and community. In these settings it is possible to obtain more realistic and thorough evaluations of the client and their environment. Aware that the public health nurse is the most critical link for finding hard to reach client population, who are known to have a difficult time navigating the health care systems and often fall through the cracks, all RN's were trained in case management. Additionally, MCH staff provide outreach activities to community based agencies and businesses, strengthening community bonds and letting families know what resources are available. This collaboration has increased efficiency and the depths of service provided.

Funding Sources

- City/county government funds
- MCH Block Grant funds
- Other federal funds (Healthy Tommorrow)

Budget
$170,000

Partnerships

"Partnerships have been established... for follow up of high risk clients, to distribute health literacy related information and to secure donated goods for community health events."

Partnerships have been established between MCH and private hospitals (for follow up of high risk clients), neighborhood businesses (to distribute health literacy-related information and to secure donated goods for community health events), churches, other city services and community agencies to share information about services provided and educate one another about a community's needs.

Leadership Enhanced?

It is difficult to assess whether leadership has been enhanced with certainty because of the state flux in health systems, but there are noticeably more inroads to the community as a result of redirecting efforts.

Barriers & Strategies

Barrier 1: Competition among health care providers for medical dollars.

Strategy 1: 1) Participate in state pilot Medicaid managed care program that requires public health to be a part of the managed care system. 2) Make opportunities to sit at the outreach table with former adversaries and collaborators. 3) Have staff regard each client as a customer whose business is appreciated.

Barrier 2: Public health nurses accustomed to specialty services in clinic settings must accept, believe in, and incorporate a return to community focused care.

Strategy 2: 1) Re-educating and rethinking how important community health nurses and health promotions are to the health of the community. 2) Form teams of staff to develop outreach strategy. 3) Provide time in work schedules for community directed activities.

Objectives / Data / Accomplishments

The program is mandated by a capitated reimbursement system from one funding source to maximize Medicaid enrollment and serve as many non-Medicaid clients as possible. Outcome measures for case management and child health include: enrollment in WIC, Medicaid, up-to-date immunizations, and appropriate use of emergency rooms. Data is collected in a pilot dBASE. Some of the successes of MCH staff reaching into the community include: private hospitals which have increased referrals to MCH and have requested MCH expertise in program decisions, police and fire personnel have read in clinics to waiting children; librarians encouraged families to improve reading skills; and MCH nurses were chosen to model public health behavior for the Christian Medical Association.

Program Evaluated?

No.

Would It Work Elsewhere?

Because the role of public health is in a state of flux, communities need to be aware of and educate their leaders about the cost effectiveness programs. During this time of change, public health has the opportunity to create a new vision of services that would strengthen the well-being of the individual, the family, and the community.

Replicated Elsewhere?

Unknown.

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Initiative Categories

Access to Care	Strengthening Public Health
• Expanding private linkages • School & health connections • Other outreach activities	• Staff training • Building coalitions & partnerships

Initiative Description

"Three technicians are employees of the Health District, one works at a school-based clinic, another at a community-based clinic, and the sixth is a medical assistant at a pediatrics office."

In an attempt to increase the providers for immunizations throughout the county, the Health District opted to pursue three different avenues.

1) Implementation of the Immunization Administration Course to train technicians to give immunizations under the direct order of a licensed professional was done in July and August, 1995. This course consisted of 70 hours of theory and clinical and graduated six technicians. Three technicians are employees of the Health District, one works at a school-based clinic, another at a community-based clinic, and the sixth is a medical assistant at a pediatric office.

2) Simultaneously, the school district director of nursing approached the Health District with the request to orient 58 school nurses to immunization administration. Twelve hours of classroom instruction followed by three days of clinical practice will complete the formal training phase. In addition, a committee of school nurses will draft the standing delegation orders which will be reviewed, revised as needed, and approved by the health district medical director or his designee. This process will also apply to the Emergency SDO. The school nurses will work under the orders of the Health District.

Funding Sources

- City/county government funds
- Other federal funds

Budget
$20,000

3) The health district is also provided an eight-hour classroom instruction with clinical practice to follow for a group of paramedics and nurses. This group works with a private ambulance service in the county. Functioning under the orders of their medical director, this group will make use of whatever site is available in the county areas to provide immunizations.

4) The El Paso County Medical Alliance, composed of the wives of physicians, have provided the liason between agencies and individuals to obtain volunteers for clinics as outreach when staff is available.

Partnerships

See text...

The role of the Health District has been to bring together those partners from the Immunization Action Plan funded in 1992 to strategize on the methods available among the players which would assist in meeting the 1996 goal. This addresses not only goals for children, adult immunizations are also included.

Leadership Enhanced?

The Health District is already viewed as the agency which maintains the practice of immunizations currently in El Paso. Therefore, when a void occurs regarding this activity, through the IAP the Health District can call together those players who may be able to assist in some way to fill this void.

Barriers & Strategies

Barrier 1: Setting aside time to do the classes.

Strategy 1: Ms. Quiroga quickly realized that certain responsibilities had to be delegated to other staff members. In addition, the medical director assisted in finding a candidate to fill the immunization coordinator position. This will help tremendously in continuing those efforts which will need to be addressed in closing these projects.

Objectives / Data / Accomplishments

Details not available at this time; however, all projects are in progress.

Program Evaluated?

No.

Would It Work Elsewhere?

This initiative would work if all players are willing to overcome those barriers which are identified early in the project. Constant communication is essential. More private/public initiatives are being created through this process.

Replicated Elsewhere?

NA

Forth Worth, Texas

Increase EPSDT Screening of Children 0-2

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Initiative Categories

Child Health	Access to Care
• EPSDT screenings	• Mobile vans/ clinics for outreach • Increasing access to Medicaid

Initiative Description

"The Health Department contracted with a private marketing firm to develop culturally sensitive approach to educate the community and providers regarding medicaid."

Eighty percent of children eligible for EPSDT screening were not screened. The state of Texas contracted with Tarrant County Health Department to devise a plan to increase screening of children 0-21 years of age. The state will pay various fees, depending on encounters for education and actual screening of children.

The health department contracted with a private marketing firm to develop a culturally sensitive approach to educate the community and providers regarding medicaid and established a "hot line" for referrals to a physician, clinic or dentist.

The staff assures the referral list is kept current to assure an appointment. A workshop was provided for office workers to help negotiate the complicated Medicaid paper work.

Funding Sources

- SPRANS funds
- MCH Block Grant funds

Budget
NA

Partnerships

See text...

The Health Department partners with the state Medicaid office to develop education, a telephone "hot line" and marketing strategies to increase EPSDT screens in Tarrant County.

Leadership Enhanced?

Yes. The Health Department had total responsibility in developing a program sensitive to the citizens of Tarrant County.

Barriers & Strategies

Barrier 1: Gaining trust of regional office previously responsible.

Strategy 1: Weekly meetings in the early planning stages of the planning process to gain trust and cooperation of the regional office.

Barrier 2: A short time frame to increase funds.

Strategy 2: The Health Department contracted with a marketing firm which had some experience working with the target population.

Objectives / Data / Accomplishments

Yes, the program has measurable objectives. Data are collected using logs and patient profile forms and will be analyzed when the program ends August 31, 1995.

Program Evaluated?

No.

Would It Work Elsewhere?

Yes, there should be enough time to do a thorough community assessment to ascertain characteristics particular to the community.

Replicated Elsewhere?

Don't know.

Laredo, Texas

Laredo Immunization Coalition

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Initiative Categories

Child Health	Access to Care
• Immunization • Early intervention • School-linked/ based activities	• Overcoming cultural barriers • Schools & health connections

Initiative Description

"Throughout the year, free clinics or health fairs are scheduled in different areas of our community to provide services for children such as immunizations, vision and dental screenings, and physicals."

The Laredo Immunization Coalition (LIC) shares the initiative of the "Shots Across Texas" campaign, to fully immunize all children ages 0-2 years. Along with the City of Laredo Health Department, members include other health-care providers (private physicians, community health center, hospital), child advocacy and child care organizations, and local school districts.

A wide variety of volunteer groups and sponsors have joined together to bring their resources of money, in-kind donations, publicity, and volunteers to supplement health department resources. Throughout the year, free clinics or health fairs are scheduled in different areas of our community to provide services for children such as immunizations, vision and dental screenings, and physicals. Also available are blood pressure checks and blood glucose screenings for adults.

Webb County is located on the Texas side of the United States-Mexico border with a population of 152,769 (1994 Census) of which 94 percent are Hispanic. One of every three Webb County residents struggle to survive on incomes below the federal poverty level. The area's economic, social, and health status is highly impacted by the continual changes in the population flow between the two countries due to immigration, tourist, and business activity.

The cooperation and determination of the members of the Laredo Immunization Coalition are the driving forces in bringing health services to the people of our community.

Funding Sources

- City/county government funds
- Other: private business, donations & inkind services

Budget

Operates through funds budgeted for immunization

Partnerships

See text...

The City of Laredo Health Department chairs the organization and provides personnel and essential supplies during events.

Leadership Enhanced?

Members of the Laredo Immunization Coalition perceive the health department as the leader of the group because of the many resources the health department provides. Through the health department, various services have been provided by other community agencies which have contributed to the success of the events.

Barriers & Strategies

Barrier 1: The shortage of nurses minimizes the number of clinics the LIC could plan through the year.

Strategy 1: It is anticipated that the number of nurses will increase with the formation of the nursing program at Texas A&M International University in Laredo, opened in 1995.

Objectives / Data / Accomplishments

Upon entering a scheduled clinic or health fair, participants provide valuable information at registration regarding financial background, ethnicity, family size and ages, and school district. As the participant receives a health service, results are noted. Referrals are made if the results show abnormal readings, for example, in vision or hearing screenings, the data is collected at the exit of the clinic or health fair. This data is then analyzed to show the number of immunizations administered, the number of children who received these immunizations and other services, the percentage of those children age 0-2 years, lost opportunities for the children who did not come with the family, and the percentage of school-age children receiving their immunizations for school records.

Program Evaluated?

No.

Would It Work Elsewhere?

The success of this initiative is due to the caring nature of members of the LIC, local businesses and organizations. With their help and cooperation, success is easier to attain. Any community who shares these common interests and beliefs can succeed.

Replicated Elsewhere?

No.

Mesquite, Texas

Integrated Client Encounter System (ICES)

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Initiative Categories

Child Health
- Immunization
- Early intervention
- EPSDT screenings

Strengthening Public Health
- Building MCH data capacity
- Immunization tracking & recall

Access to Care
- Case management

Initiative Description

"...a computer program developed by the Texas Department of Health to automate much of the documentation and record-keeping required of public health facilities."

Integrated Client Encounter System (ICES) is a computer program developed by the Texas Department of Health to automate much of the documentation and record keeping required of public health facilities. It will reduce paperwork, save time, and help workers be more efficient. ICES stores client demographic information and detailed records of the services clients receive. Some of the areas covered include: appointment calendar, case management, child health, client diagnoses, client registry, performance monitoring, electronic billing (medical reimbursement), family profile, immunizations, health history, health risk profile, mass screening, primary care, vaccine inventory and custom reporting.

The ICES architecture allows patient history to move as needed between the clinics using ICES software. Data can easily be moved to all sites where the patient receives services or can be brought to a central administrative location. The data is supported by a multitiered security system definable to the specific needs of the site.

It is a "point-of-service system." This means that each clinic worker providing services (client registration, immunizations, etc) should have immediate microcomputer access to enter or review client information. A standard ICES installation is one local area network (LAN). The site's LAN is connected to a wide area network (WAN) by a high speed data line. This network structure allows ICES clinics throughout the state to share data.

Funding Sources

- City/county government funds
- Other federal funds

Budget
$60,000

Partnerships

"The agreement defines a mutual understanding between ICES support staff and the city of Mesquite toward enhancing the joint partnership relationship."

An agreement between the Texas Department of Health and the City of Mesquite defines the equipment and services provided by ICES and the responsibility of the city in implementing the software and hardware at the public health clinic. The agreement defines a mutual understanding between ICES support staff and the city of Mesquite toward enhancing the joint partnership relationship.

Leadership Enhanced?

Yes. Our communication and working relationship with the Texas Department of Health and with the County are significantly enhanced. The ability to more effectively network and identify needs enhance the clinic's leadership role regarding community health.

Barriers & Strategies

Barrier 1: City Council approval for funding monthly line charges.

Strategy 1: Convinced Council that the system would reduce paperwork, save time, and help staff be more efficient. That it would positively impact services provided by the clinic to the community.

Barrier 2: Training and time to input data from pre-ICES client records.

Strategy 2: Initial training provided by the Texas Department of Health. Ongoing training of staff promotes effective use of the system. Did internal audit to establish quantity of existing client records that needed to be entered into the ICES system.

Objectives / Data / Accomplishments

The specific measurable objectives are to track and contact clients for follow-up services. We will be able to measure performance and outcomes through the preparation of applicable client forms and custom reporting. Data are collected through user defined forms, and the system can prepare statistical reports as needed.

Major accomplishments to date include better tracking of clients for recall, more effective retention of client records, vaccines inventory and ordering. We began the ICES system in June and will be able to cite relevant positive accomplishments the longer we use the system.

Program Evaluated?

No. Formal evaluation will be next spring, however, ongoing evaluation is very positive.

Would It Work Elsewhere?

Yes. The improved data information quality and access will positively impact services provided by a clinic to the community. The ability to share client information between programs and agencies facilitates health care services. It is cost effective, reduces paperwork, and duplication of client information.

Replicated Elsewhere?

Yes. Andrews City, El Paso City, Dallas County and Harris County.

Salt Lake City, Utah

Breast & Cervical Cancer Early Detection

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Initiative Categories

Womens Health	Access to Care
• Breast/cervical cancer	• Overcoming cultural barriers • Clergy & health connections • Other outreach activities

Initiative Description

"All (breast and cervical cancer) screening services are provided based on a sliding fee scale to any woman over twenty years of age."

The Breast and Cervical Cancer Early Detection was designed and targeted toward non-white women more than 40-years old. It included marketing and outreach efforts as well as the clinical services. All screening services are provided based on a sliding fee scale to any woman over 20 years of age. Funding is available for mammogram for women over 40 who qualify. Additional funding exists from the Utah Department of Health for some diagnostic services.

This project offered an opportunity for the first collaboration between the Bureau of Health Promotion and Education and the Bureau of Public Health Services within the Division of Family Health Services. The responsibilities of the clinical bureau included identification of sites, staffing, supplies, training, scheduling and documentation for billing. Health Promotion was responsible for marketing the service to the community, development and production of educational materials and products used to educate the division staff, clients and the community.

Outreach efforts included the formation of the Salt Lake Cancer Awareness Team, a multidisciplinary team focused on increasing awareness in the valley. Multiple outreach strategies were used to get information into the community. A phone number (468-CARE) was established and advertised so women could call and receive educational materials or make an appointment. This summer we launched "Women Reaching Women," a grass roots based outreach project which focuses on the 204 congregations not associated with the predominant religion in the valley.

Funding Sources

- City/county government funds
- General state funds
- Other federal funds

Budget
$45,000

Partnerships

"Our health department created a centralized phone line for information and appointments."

A representative of the health department has been a member of several community coalitions working toward cancer awareness and education. Stronger partnerships have been formed with our counterparts at the state health department. Our health department created a centralized phone line for information and appointments, provided training to lay outreach workers and facilitated the formation of a speakers' bureau.

Leadership Enhanced?

Yes. We have established a coordinated effort from our health department addressing cancer screening.

Barriers & Strategies

Barrier 1: Role definition and communication internally.

Strategy 1: Formation of an oversight committee to redefine roles has been helpful. Talking about the issues so there is common understanding of the direction.

Barrier 2: Requirements and rules from the state seem to change a lot.

Strategy 2: When a program is designed based on one set of rules, it is difficult to do a full turn in mid-stream. We remind ourselves to remain flexible.

Objectives / Data / Accomplishments

To date, we have screened 292 women since January 1995. We will evaluate based on numbers. The effectiveness of specific outreach strategies will be measured at the end of the year.

Program Evaluated?

No.

Would It Work Elsewhere?

Yes. The components exist in some form in all communities and adjustments are easily mode. Outside resources usually exist in communities.

Replicated Elsewhere?

Don't know.

Richmond, Virginia

Richmond Healthy Start Initiative

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Initiative Categories

Access to Care
- Reducing transportation barriers
- Home visiting

Adolescent Health
- Teen pregnancy

Strengthening Public Health
- Infant/child death review activities
- Building coalitions
- Building MCH data capacity

Initiative Description

"The Healthy Start Consortium consists of agencies and individuals interested in reducing infant mortality and improving the maternal and child health system in the city of Richmond."

In late 1994, the city of Richmond received a two-year, $2 million grant from the U.S. Department of Health and Human Services, to be administered by the Richmond City Health Department (RCHD) in conjunction with the newly formed Healthy Start Consortium. The mission is to reduce the number of occurrences of infant mortality in the city of Richmond. Our project goals are to:

1) Establish an expanded partnership of consumers, organizations and individuals to improve the organization of resources for women, children and their families.

2) Improve the health of women, infants, and children through expansion of existing and continuing services to targeted zones of the city where the greatest need exists.

3) Reduce barriers to access by expanding and strengthening key facilitating services available to at risk populations by supporting community-driven and community-based programs designed to address community-identified needs.

4) Increase community awareness and support programs that are designed to heighten awareness, alter attitudes and behavior, and increase knowledge of the issues affecting the reduction of infant mortality.

Funding Sources

- Federal funds

Budget
$1,000,000

Almost 80 percent of the funding received by the Healthy Start Initiative is distributed to local agencies and organizations to provide direct services in the following areas:

- lay mentoring/home visitors for first time teen mothers and their partners
- transportation and short-term child care for targeted mothers for medical appointments
- teen pregnancy prevention education
- health awareness programming in middle schools, recreation centers, and churches
- Infant Mortality Review Council
- expand perinatal case management for non-Medicaid eligible women
- expanded availability of perinatal substance abuse services
- Healthy Families Richmond.

Partnerships

The Healthy Start Project Manager reports directly to the Director of Public Health and all Healthy Start employees are employees of RCHD.

The Richmond City Health Department (RCHD) coordinated the grant development for Healthy Start. They provide all fiscal management and administrative support services. The Healthy Start Project Manager reports directly to the Director of Public Health, and all Healthy Start employees are employees of RCHD. Many RCHD program staff are active members of the Healthy Start Consortium.

Leadership Enhanced?

Yes. The Healthy Start Project Manager is part of the RCHD management team and participtes in agency planning activities. The Project Manager also assisted in expanded capacity for interagency involvement.

Barriers & Strategies

Barrier 1: Discouraged seeking grant funds due to purchasing policies.

Strategy 1: Extensive technical assistance was provided to community based applicants who submitted marginal proposals that contained underdeveloped program concepts. An additional 30-hour per week staff person was hired to provide more intensive ongoing technical assistance around program development.

Barrier 2: Limited client and customer involvement in the consortium.

Strategy 2: Meetings were held in community churches. Conference sponsored focused on citizen and consumer education with transportation and childcare provided. Consumer involvement committee formed.

Objectives / Data / Accomplishments

Measurable objectives have been developed for each project including specifying the numbers of clients served by each program. A variety of data collection methods are used. Qualitative data are being collected to measure changes in the levels of integration in the MCH service delivery system. Client-level data are being collected through Client Uniform Reporting System (CURS) including numbers of hours and services received from each funded service provider. A program reporting form is utilized to capture data for large group education sessions. A pilot evaluation is being developed for teen pregnancy prevention programs wherein a unique client identifier for each participant will be matched to Electronic Birth Certificate records regularly after program completion to determine long-term impact.

Major accomplishments: Initiative staffed, office opened, 12 programs established and serving clients, consortium was organized; two-day conference held, relationships established with other agencies and coalitions.

Program Evaluated?

No. Program only has been in operation since January 1995.

Would It Work Elsewhere?

Yes.

Replicated Elsewhere?

Yes. Twenty-one other sites including Baltimore, Chicago, New York and Philadelphia.

Seattle, Washington

Healthy Families - King County

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Initiative Categories

Access to Care	Child Health
• Increasing social support systems	• Early intervention • Injury including child abuse

Initiative Description

"This program is unique in that it offers universal referrals from participating hospitals at time of birth to two of the health department sites involved in the program."

Healthy Families King County is a local modification of an early parenting support, child abuse prevention program in Hawaii called "Healthy Start." With decreased hospital stays after birth, more families are being discharged to go home within 24 hours of birth and do not have access to adequate education, resources and supportive services through the delivering hospitals. Often there is little time for the hospital staff to gather assessment information and "high risk" behaviors not demonstrated during hospital stay. This offers universal referrals from participating hospitals at time of birth to the health department sites involved in the program.

An initial screening assessment is completed by a public health nurse. The nurse assesses the health status of the mother and infant, answers any questions the parents might have and explains and offers home visiting services.

The Healthy Families team then provides individualized, family centered, services according to each family's needs and goals. Services are provided through a multidisciplinary approach including professionals and paraprofessionals (public health nurses, social workers, family advocates, family support workers, and parent aide volunteers). One of the pilot sites also has a Family Resource Center and offers parenting classes, supportive groups and activities to all parents in the community with newborns and young children up through age five, regardless of participation in the home visiting services.

Funding Sources

- City/county government funds
- Medicaid insurance

Budget
$280,000

The family is an integral member of the home visiting team and decisions affecting the services offered to a family are made by the team and the family. Services are provided over a period of time dependent on the family's needs. Participation in the program is voluntary and those families who do not wish to continue with the program, or are receiving adequate assistance through other programs, are encouraged to self-refer at any time in the future.

Partnerships

See text...

The Health Department was involved in the initial community forums and discussions and has provided leadership for the community and other service provision agencies for the planning, implementation and evaluation phases.

Leadership Enhanced?

Yes. Due to leadership in interagency collaborative efforts; facilitation of individual, family and community data collection, analysis and interpretation, and leadership in evaluation of services as well as the program service delivery model for meeting the future needs of the community in an effective and meaningful way.

Barriers & Strategies

Barrier 1: Multiagency, multisystem collaboration.

Strategy 1: Continued efforts to communicate facilitate discussions, negotiate, and train staff to provide continuity of service from the time of delivery and referral from participating hospitals to the time of discharge from the program.

Barrier 2: Adequate funding to meet needs and requested expansions.

Strategy 2: Continued efforts to obtain funding from multiple sources and coordination of in-kind agency contributions.

Objectives / Data / Accomplishments

Objectives include, but are not limited to:

- 80 percent of mothers receiving intensive home visiting services will demonstrate more positive interaction with their children, state age-appropriate expectations of them, and exhibit fewer behaviors associated with child abuse and neglect
- 70 percent of the families involved in intensive home visiting services will make significant progress toward, or attain 75 percent of their goals
- 80 percent of the families involved in the intensive home visiting services will report and increase in knowledge and awareness of community resources (Auburn only-collected through immunization information, etc.)

Program Evaluated?

Yes.

Would It Work Elsewhere?

Yes. The model would need to be modified to meet the unique needs of the community, as was done in King County.

Replicated Elsewhere?

No. But current plans include two expansion sites in King County for 1996. However, the Healthy Start model from Hawaii has been replicated in many communities across the United States.

Spokane, Washington

Child Death Review Committee (SCSDRC)

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Initiative Categories

Strengthening Public Health
- Building coalitions
- Building MCH data capacity
- Infant/child death review

Initiative Description

"Deaths are classified by cause of death as either non-preventable or preventable by means of interventions available within the community."

The Spokane County Child Death Review Committee began its development in October of 1991 with participants from Spokane County Health District (SCHD), the medical community, law enforcement, the coroner's office, the county prosecutor's office, the emergency medical system, Child Protective Services, and the Regional Center for Child Abuse and Neglect.

Between 1991 and 1993 the group evaluated the best working models of pediatric death review committees throughout the U.S. as well as models and guidelines proposed by national organizations. The committee also drew extensively from the Los Angeles County and Colorado State Child Death Review, the American Bar Association Center on Children and the Law, and Dr. Hendrika Cantwell.

In 1994, SCCDRC began reviewing all deaths of children less than 18 years of age occurring in Spokane, regardless of their county, state or country of residence. At present, Spokane County has the only comprehensive, multi-disciplinary, county-wide death review team in Washington state for children from birth through adolescence.

Funding Sources

- In-kind services
- One time grant for $29,000 to develop a data management system

Budget
NA

Deaths are classified by cause of death as either non-preventable or preventable by means of interventions available within the community. The committee specifically examines whether deaths involved unintentional injury, intentional injury or maltreatment. The committee meets monthly to review cases reported to the SCHD vital statistics office. Deaths of Spokane County residents who die elsewhere are not reported locally or available for review. No fetal deaths are reviewed. Information obtained from the analysis is used to plan public education efforts around risk prevention.

Partnerships

See text...

SCHD has taken the leadership role from the inception of SCCDRC with strong multi-disciplinary community support and participation in all phases of development and implementation of the death review committee.

Leadership Enhanced?

The highly visible nature of the public health interventions as a result of the work of the SCCDRC has increased public awareness of SCHD's leadership role in improving the safety of Spokane County's children.

Barriers & Strategies

Barrier 1: Accessibility of information to conduct comprehensive review.

Strategy 1: Process is ongoing. Washington state legislation clarifying and defining the need, purpose, and legal operation of death review teams for infants less than one year of age (1993), and extending comprehensive reviews to deaths of all children from birth through age 17 (1994). SCCDRC also seeks the assistance of other agencies, including the Washington State Center for Health Statistics and Wahsington State Attorney General.

Barrier 2: Confidentiality issues.

Strategy 2: Interagency agreements to share data need to be developed. Each committee member signs confidentiality statement. Work still needs to be done in the area of accessing the confidential section of birth certificate.

Objectives / Data / Accomplishments

The measurable objectives of SCCDRC are to describe patterns and trends of child deaths in Spokane County, identify areas where intervention is needed, and to increase community awareness of child safety issues. An immeasurable objective is to improve interaction between community agencies which is much more difficult to measure, but equally important.

A summary evaluation form is completed for each death reviewed. The data compiled on that form is entered into a data management system that uses computer hardware to maintain an electronics database, a customized software application to simplify data entry, maintenance, and security, software for aggregate data analysis, hardware and software to prepare presentation materials, and software to prepare a report file suitable for publication and distribution.

Program Evaluated?

Yes.

Would It Work Elsewhere?

Yes. It requires a significant commitment of human resources and an adequate data management system. This model follows the mandate of the Washington State Public Health Improvement Plan of Assessment, Assurance and Policy Development.

Replicated Elsewhere?

No. There are currently several child death review committees being developed in Washington.

Tacoma, Washington

Family Support Center Iniative

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Initiative Categories

Perinatal Health
- Home visiting

Child Health
- Early intervention
- School linked/ based services

Access to Care
- Schools & health concerns
- Increasing social support systems

Strengthening Public Health
- Building coalitions

Initiative Description

"This collaboration model is designed to improve service accessibility by relocating existing programs at Family Resources Centers, either within an elementary school or established neighborhood center."

In 1994, The Tacoma-Pierce County Health Department committed state and local resources toward the development of the Family Support Center Program. Bringing together a multidisciplinary team of service providers from public, private and community agencies, the program goals are: 1) to support and expand prevention strategies that have demonstrated successful outcomes (Healthy Start, ECEAP, Readiness to Learn) and 2) to facilitate a county-wide shift in health and social services into an integrated continuum of prevention and early intervention services to families of "at risk" children, birth though age eight.

This collaboration model is designed to improve service accessibility by relocating existing programs at Family Resources Centers, either within an elementary school or established neighborhood center. Other elements of the model include:

- active grass roots participation in planning, service delivery and local oversight (culturally sensitive)
- community based family support workers (paraprofessional advocates) and public health are required staff at each center
- families are active partners in developing service plans

Funding Sources

- City/county government funds
- General state funds
- United Way
- Private industry funds

Budget
$1,534,764

Partnerships

"...partnership was formed with educational, quasi-governmental, nonprofit and business entities to expand and replicate the Family Support Program model."

In 1994, the health department initiated the Family Support Center concept by committing local and public health improvement dollars to establish seven sites throughout Pierce County. In 1995, a prevention partnership was formed with educational, quasi-governmental, nonprofit and business entities to expand and replicate the Family Support Program model.

Leadership Enhanced?

Yes, leadership is shared at all levels as community-based staff participate in all phases of program development through community assessment, policy development and assurance activities.

Barriers & Strategies

Barrier 1: Established practices impede coalition building.

Strategy 1: Over time, the development of trust and mutual respect is contributing to the formation of acceptable roles and systems to support initiative activities.

Barrier 2: High risk individuals vs public health prevention approach.

Strategy 2: In process-through education and redirection of health department resources, community and coalition partners are becoming aware of public health core functions: assessment, policy development and assurance. Health department focused on prevention to efforts-targeted populations.

Objectives / Data / Accomplishments

The goals and objectives correlate with the goals in the Washington State Public Health Improvement Plan:

- increase broad based community support for children and families
- reduce child abuse and neglect
- increase number of children who receive services consistent with physical and emotional health and developmental norms
- increase number of children actively engaged in school and performing at grade or capacity

Program Evaluated?

Yes.

Would It Work Elsewhere?

Yes. Researched and validated community development models are basis for Tacoma-Pierce County Health Department Family Support Center Initiative.

Replicated Elsewhere?

Don't know.

Madison, Wisconsin

Joining Forces for Families

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Initiative Categories

Access to Care
- Overcoming cultural barriers
- Expanding private sector linkages
- Schools and health connections
- One-stop shopping

Access to Care
- Increasing social support services

Strengthening Public Health
- Building coalitions and partnerships

Initiative Description

"Major implementation strategies are presence of front line staff in a neighborhood office, participation of neighborhood residents, and joint planning and collaboration at the agency level."

Joining Forces for Families (JFF) is a multiagency, collaborative model for community-based, prevention-focused health and human service delivery. Pivotal principles of the JFF approach are recognizing and using strengths of families and the community and are being directed by community ideas and initiatives.

Major implementation strategies are presence of front line staff in a neighborhood office, participation of neighborhood residents, and joint planning and collaboration at the agency level. The planning stages of the JFF project began when government and agency leaders convened front line staff from each agency to take a critical look at current health and human service delivery and to use the knowledge gained to improve services. Early goals were to improve accessibility and appropriateness of services to troubled families, avoid service duplication, and to describe barriers to successful outcomes.

Funding Sources

- City/county government funds
- United Way, Madison Community Foundation

Budget
$220,000

Goals were expanded to include progress and change on individual/family, community, and systems levels. Front line staff advocated for the participation of neighborhood residents inservice design and sought systems change in a direction toward prevention and away from tertiary intervention.

We advocated for a multidisciplinary team approach based out of a neighborhood office and the ability to respond directly to resident and community requests and ideas rather than only to referrals through our agencies. The City of Madison already had public health nurses and police officers serving neighborhoods. In advocating for a team approach, we also included community-based school staff and social workers without child protective services caseloads. Neighborhood residents and leaders advise neighborhood teams, refer families to the team, involve teams in community events, and participate in agency hiring processes.

On a daily basis residents can seek information, referral, consultation and directly access services of partner agencies from the neighborhood office. We have greater opportunity to serve people and catch problems earlier and rely on family capacity and community resources rather than on formal agency intervention in many cases.

Partnerships

"Partner agencies are Dane County Department of Human Services, Madison Department of Public Health, Madison Police Department, United Way and Vera Court neighborhood leaders and residents."

The health department has had a leadership role in designing JFF. We had the most experience with prevention-oriented, community-based practice focusing on family, community, and systems levels. Public health nurses involved in the planning phase were instrumental in forming guiding principles which included resident participation, being neighborhood-based, and focusing beyond the individual/family case management model to the community and systems levels. The health department contributed additional front line staff time, management participation and resources to the project. Public health nurses have been instrumental in articulating the JFF approach and in the development of the evaluation plan.

Leadership Enhanced?

The department and individual public health nurses have a higher profile as experts in community-based practice with other city departments. In addition, other government and community agencies consult and interact more with health department staff about community work, health and social issues. Public health nurses have helped highlight the health department leadership role in JFF by publishing an article in a state-wide nursing publication. A public health nurse won an award from the University of Pennsylvania School of Nursing for an innovative nursing practice. This enhanced the leadership role of the health department within the city and generated interest from other providers.

Barriers & Strategies

Barrier 1: Collaboration among agencies with different missions, goals and agendas.

Strategy 1: JFF is working to overcome these barriers by recognizing it as a natural feature of the collaboration process. Also, a structure is in place to assure communication and information flow. This structure includes an oversight committee, an operations committee and committees internal to each ageny.

Objectives / Data / Accomplishments

JFF developed evaluation criteria related to individual and family progress, community progress, and systems change. Input from community residents and leaders was an important consideration in development of these criteria. We are involved in pioneering an approach to services and value qualitative description aimed at articulating our newly gained knowledge base for others to use. Accomplishments include: Improving customer focus, accessibility; appropriateness of partner agency services; reducing barriers to resources; decreasing isolation and increasing participation of residents in community activities; shifting the focus on family, community, and systems levels toward prevention; implementing prevention-focused programming in high-risk community settings; delivering fewer unnecessary, unhelpful, or duplicated services to families; and, recognizing and using, to a greater degree, the capacities, strengths, and resources of families and the community. Several examples of initiatives are as follows:

- host community school readiness events including school registration, school supplies, and immunizations
- hold an adult health screening clinic
- support neighborhood residents advocating against a liquor license for a local store
- help organize and host a bicycle rodeo, safety promotion event, and helmet give away

Program Evaluated?

Yes.

Would It Work Elsewhere?

Literature indicates that there is no current program that replicates the JFF project. We can say that an initiative which rests on the guiding principles of the JFF approach would enjoy some successes in another urban community.

Replicated Elsewhere?

No.

Milwaukee, Wisconsin

Newborn Screening Project

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Initiative Categories

Perinatal Health	Child Health
• Home visits	• Children w/ special health care needs
	Access to Care
	• Expanding private sector linkages
	• Case management

Initiative Description

"...project began as one to insure care for those infants with sickling disorder and has expanded to include any infant identified with a definite abnormal finding on the first sample for newborn screening who does not receive repeat testing."

Newborn screening is the testing of infants at birth for rare congenital disorders. In Wisconsin, the panel includes seven tests. Prior to October of 1988 and the addition of hemoglobinopathies, there had been consistent follow-up for all infants identified with a disease. During the first six months of screening for hemoglobinopathies, only one third of identified infants received follow-up. At this point, a cooperative agreement between the State of Wisconsin's Bureau of Public Health and the City of Milwaukee Health Department began.

The concentration of cases with hemoglobin disorders resides within the southeast region of Wisconsin. This, along with the ability of the public health nurses to locate and case manage children, made the Milwaukee Health Department a perfect choice for implementation of this program in July of 1989.

Since July of 1989, every infant identified with a sickling disorder has been referred to the coordinator of the program who is a Public Health Nursing Supervisor with the health department. A personal contact is made with the physician of the infant and a plan developed for the collection of a whole, confirmatory blood sample and referral for comprehensive care if a sickling disorder is confirmed. Services are available through the health department to collect the necessary referrals. Follow-up phone calls and visits are completed until the infant is seen in the comprehensive Sickle Cell Clinic in Milwaukee or the hematology clinic in Madison, and penicillin therapy has begun.

Funding Sources

• Surcharge

Budget
$100,000

This project began as one to insure care for those infants with sickling disorder and has expanded to include any infant identified with a definite abnormal finding on the first sample for newborn screening who does not receive repeat testing. This has meant intervention for many infants with elevated galactose levels, one allele for cystic fibrosis, elevated thyroid results, hospital discharge without testing and unsatisfactory samples. Each infant is followed until testing is completed and care is obtained or the levels have returned to normal. To date nearly 500 infants, including more than 75 infants with sickling disorders, have received public health intervention.

Partnerships

"The newborn screening coordinator has developed linkages with with HMOs, hospitals, private medical providers, Children's Hospital and local health departments throughout the state."

There have been several partnerships developed because of this project. The Milwaukee Health Department, State of Wisconsin Bureau of Public Health and State Laboratory of Hygiene work cooperatively on this project. "The newborn screening coordinator has developed linkages with HMOs, hospitals, private medical providers, Children's Hospital and local health departments throughout the state."

Milwaukee, Wisconsin — Newborn Screening Project

Leadership Enhanced?

The leadership of the health department has been enhanced through representation on the advisory committees that govern newborn screening. The Coordinator is involved with several committees that make decisions on the testing and follow up infants. The public health setting has proven to be an asset when planning for these infants to receive follow up care and access to newborn screening.

Barriers & Strategies

Barrier 1: Physician knowledge of hemoglobin testing at birth.

Strategy 1: Personal contacts with physicians were made by the coordinator. Information presented included studies that support screening for hemoglobinopathies at birth and the necessity for both penicillin therapy and comprehensive care. Follow-up care was coordinated with the private physician and clinics, with reassurance that the infant would be returning to the primary physician for ongoing care.

Barrier 2: Requirement for repeat blood tests.

Strategy 2: Personal contact to physicians and hospitals is made by the coordinator to explain the need for repeat testing and offer a home visit for any infant requiring repeat tests. The home visit component has worked well for the families in insuring that the tests are completed.

Objectives / Data / Accomplishments

The work plan for this project contains numerous measurable objectives. For example, the testing of all infants identified with a disease state shall be accepted and triaged within three working days. A computer program stores data on each infant referred. Data are collected that compares, the referral date with the first date of intervention.

Another objective is that agency services are documented and a final disposition indicated. Again the computer program contains information on final results and disposition. A hard copy is kept for all infants requiring intervention.

To date, each infant who has been referred to the project with any of the disorders identified on the newborn screening panel has received access to medical care and the required follow-up suggested by the advisory committees. Several teaching tools and posters have been developed for the education of the community. Overall there is an increased awareness of newborn screening and the importance of this screening to the health to newborn infants.

Program Evaluated?

No.

Would It Work Elsewhere?

Yes. However access to a public health department that provides a home visiting component is crucial to the replication of this project.

Replicated Elsewhere?

No. Various newborn clinic projects are currently in most of the 50 states. Each varies as to the content and follow-up. This exact project has not been replicated.

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